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Hospitals Should Meet Accreditation Standards

Hospital accreditation is not new. It has been in existence since 1918 when the American College of Surgeons, realizing the urgent need to improve hospital facilities and patient care, inaugurated a program of hospital standardization. During the succeeding 34 years with encouragement by the college, first under the able leadership of Dr. Franklin H. Martin and followed in 1923 with Dr. Malcolm T. MacEachern's brilliant direction and insight, American and Canadian hospitals became recognized throughout the world for their high standards of patient care.

With the increasing importance of this service and the growth of hospitals the college found it could not do the work alone. In 1952 five incorporated bodies vitally interested in the health problems in the United States and Canada pooled resources and personnel and formed the Joint Commission on Accreditation of Hospitals. The commission is made up of representatives from the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and Canadian Medical Association. It is a voluntary nonprofit organization supported by contributions from its member organizations.

Following the example of the American College of Surgeons the Joint Commission on Accreditation of Hospitals does not make a charge for a survey of a hospital. Any hospital, whether it be under the ownership of a church, governmental, private nonprofit, or proprietary, which fulfills the eligibility requirements, may apply for a survey. The require-

ments set forth by the commission state that the hospital must have functioned for 1 year in its present capacity, must have at least 25 adult beds, and must be listed by the American Hospital Association. In asking for accreditation it is assumed that the governing board, the administration, and the medical staff are interested in maintaining an efficient organization and willing to apply certain fundamental principles for the efficient care of the patient which are set forth in "The Standards for Hospital Accreditation." There must be evidence in the hospital organization of a sincere desire by all groups concerned to maintain these required standards.

It is estimated that there are 7,000 hospitals in the United States and Canada eligible for accreditation. Of this number 3,857 or 55.1 per cent are accredited. In Texas it is estimated that there are 500 hospitals eligible for accreditation, and on December 31, 1957, only 109 had measured up to the minimum standards required for accreditation. This indicates that we have a long pull ahead. The reasons for the low percentage in Texas are not clear. It may be that the small hospitals do not know that they can meet the minimum standards. However, in a hospital 25 beds or over, if the medical staff, the board of trustees, and the administration recognize the advantages of accreditation in assisting them to get good patient care there would be a decided increase in the number of accredited hospitals in Texas and in the nation.

There are many obvious reasons for all hospitals to endeavor to measure up to accreditation standards. The patient is assured of the best possible treatment through a competent staff in a hospital having modern diagnostic facilities and responsible personnel. The patient should know that there is an accurate and valuable record maintained of his illness. The combination of efficient methods, professional skills, and good organization, all of which are emphasized by the commission, means that the patient profits by shorter hospitalization. There is an appreciation by all concerned that the patient benefits by these elevated standards. In many instances hospitals which are able to meet the standards required attract more qualified nurses and other skilled personnel because the hospital enjoys a higher confidence and respect on the part of the public. Of much importance is the fact that the physician knows he is the member of the staff of an approved hospital.

Accreditation is not compulsory either on the part of the hospital or the commission. It is not a governmental regulation. It presents itself more as a duty on the part of all responsible for the care of the sick to see that the standards which brought our hospitals to the very forefront are the basis of operation of all institutions caring for the sick. It is encouraging to hear that in Texas more and more hospitals are becoming interested in the commission's program. This means that we can look forward to the day when most of the hospitals in Texas which do not now enjoy accreditation will be listed in the annual report of the Joint Commission on Accreditation of Hospitals.

—LEIGH J. CROZIER, M.D., Houston.

Summer Assignment

From governor and senator to precinct chairman, the lines are being drawn for what promises to be one of the most heated political battles in recent Texas history. The Democratic Party, long dominant in the state, is split down the middle with the more conservative element rallying behind Governor Price Daniel and Senate-hopeful William A. Blakley and with the liberalists of the Democrats of Texas beating the drums for Senator Ralph Yarbrough and State Senator Henry Gonzales, gubernatorial candidate. Ultimate goal is control of party machinery leading toward a position of power in national nominations for the presidency in 1960. The Republicans, eager to become a force in Texas, are entering the races up and down the line in attempts to strengthen their position.

What does all of this mean to Texas physicians? It means that more than ever it is important that each citizen participate actively in his precinct convention. It means that each potential voter must become acquainted with the issues and the candidates and then be sure that his vote is cast, whether in person or through absentee balloting, so that no race will be won by default.

Political Calendar

July 6-22—Absentee voting for first primary.
July 26—Precinct convention.
July 26—First primary election.
August 2—County convention.
August 3-19—Absentee voting for second primary.
August 23—Second primary election.
September 9—State convention.
October 14-31—Absentee voting for general election.
November 4—General election.

Probably most physicians and members of their families eligible to vote are in the habit of voting in the primary and general elections at which county, state, and national officials are chosen. They are inclined to be less habitual in participating in precinct meetings, yet it is there that political strategy is put in motion which later formulates platforms and selects standard bearers for the party. The whole party system rests on the precinct organization, and it is there that the individual voice can make itself heard to best advantage. Often precinct skirmishes are won because of prior caucusing which makes it possible for those of similar views to get together and know what they want to do. A little advance investigation will determine when and where these caucuses are scheduled or the need for like-minded neighbors to get together in their own meeting.

It is an old saying that democracy has not been tried and found wanting, but has never been tried. Greater participation in all phases of the political course set for this summer and fall may help change the truth of that saying. No one who fails himself to share in the activity of political meetings and elections has much right to complain when the outcome is contrary to what he wants. Perhaps if he does participate, there will be no need to complain.

Supply and Demand

Merchandising experts study their prospective markets and try to be sure that they have products which will appeal to the buyers. Physicians might do well to use some of the techniques of the merchandisers.

Figures from the Physicians Placement Service operated by the Texas Medical Association suggest that the supply of physicians is not meeting the demand of communities for service in certain respects, and as a consequence, physicians specializing in some fields of practice are having difficulty getting located to their satisfaction.

General practitioners continue to be the type of physician for whom most requests come to the Physicians Placement Service. Eighty-six per cent of all requests for doctors come from communities with populations of less than 10,000, including 46.5 per cent from communities with populations of less than 2,000 persons. In more populous areas, where adequate medical care is available, there appears to be developing an oversupply of general surgeons. There has been no difficulty meeting requests for ophthalmologists, urologists, and obstetricians and gynecologists. In contrast, in addition to calls for general practitioners, there usually are unfilled requests for specialists in the eye, ear, nose, and throat combination; internists; pediatricians; neurosurgeons; psychiatrists; radiologists; pathologists; and those interested in industrial medicine.

Medical students, young physicians, and physicians not so young who consider specialization might well examine the "market" and choose a "product" for which there is a demand.

Services for Medical Students

Realizing the importance of an early and favorable introduction of the doctor-to-be to the professional organization he later will join, the Texas Medical Association has adopted a positive program for serving the medical students of Texas. Newest aspect is the Thompson Scholarship Fund, applications for which now are being accepted. Cooperation in Student American Medical Association activity and presentation of Medical Students Day programs are other projects.

The S. E. Thompson Scholarship Fund became operative July 1, when approximately $40,000 for loans to students attending the University of Texas Medical Branch became available from the half million dollar endowment left by the late Dr. Sam E. Thompson of Kerrville. Recipients of the fund must be Texas citizens who have been residents of the state for at least 1 year and who have completed their freshman year of medical school, or in case of unusual merit, first year students will be considered.

Applications for the loans may be obtained from the Executive Secretary of the Texas Medical Association or the Registrar of the University of Texas Medical Branch. Selections of recipients of loans will be made by the Trustees of the fund (Trustees of the Association plus the executive director of the Medical Branch), with the Student Loan and Scholarship Committee of the University of Texas Medical Branch serving in an advisory capacity.

Two Texas students returned recently from the American Medical Association session in San Francisco where they rubbed shoulders with physicians from throughout the nation, courtesy in part of the Texas Medical Association. To make it easier for a student from the Student American Medical Association chapters at each of the three medical schools to attend the AMA convention each year, the Texas Medical Association offers to pay part of the expense of one representative elected by the chapter of each school. Throughout the year an adviser named by the Association stands by to help the chapter any way he can.

Medical Students Day is sponsored annually for seniors of the three medical schools by the Texas Medical Association in cooperation with the county medical society where the school is located. The program was established for the purpose of contributing worth-while information which will make the students' initiation into the practice of medicine a little smoother. It is designed specifically to acquaint students with the socio-economic aspects of medical practice.

It is hoped that these various services provided by the Association will help Texas medical students to become better doctors and more active members of their professional societies.

Another Insurance Program

The third insurance service for members of the Texas Medical Association since November, 1955, is being established after approval by the House of Delegates at the recent meeting in Houston. This newest opportunity for Texas physicians is a life insurance policy at low association group rates but issued on an individual basis, since true group life insurance programs for associations are illegal in this state.

After reviewing 27 life insurance programs during the past 4 years, the Council on Medical Economics chose a plan submitted by Great American Reserve Insurance Company of Dallas for sponsorship by the Texas Medical Association. Under this plan, a uniform premium of $100 per year will be paid by the participant (a member of the Association less than 70 years of age, subject to medical examination and either an additional premium or rejection on the basis of such examination) for which he will be eligible for insurance amounting to $26,000 if he is 35 years of age or less, $15,000 if between 36 and 45, $7,500 if 46 to 55, $3,500 if 56 to 65, and $1,750 if 66 to 70. Prior to age 60, the insured will have the right to convert his

policy for any plan of life or endowment insurance issued by the company at that time. Additional details are being mailed to members.

Although the life insurance program adopted by the Council on Medical Economics for the benefit of Texas Medical Association members is designed to help especially the young physician who is most in need of life insurance coverage, older members will receive liberal amounts of insurance at low cost.

With the addition of this life insurance program, members of the Association now have available group disability, accidental death and dismemberment, and life insurance plans, all with favorable premiums and benefits and backed by their own professional organization.

Something New

A list of members of the Texas Medical Association, published each year in the *Journal,* appears in this issue. For the first time, however, arrangements have been made to permit the list to be removed from the *Journal* as a self-contained unit for independent use. Perforation and separate stapling will make it simple to tear out the membership section if that would be helpful to the reader. At the same time, the list remains an integral part of the *Journal* for binding and a permanent record.

Physicians are invited to comment on whether or not they like the flexibility of use provided by this new feature.

Reprints of the list may be purchased from the Association at 60 cents each.

★ Current Editorial Comment

Newer Developments In Occupational Health

Texas employers this year are paying more than $110,000,000 for workmen's compensation insurance. The rates are explainable; last year 230,000 reported industrial accidents produced 64,000 claims, and there were 763 deaths! We cannot neglect the monetary returns alone of prevention of such staggering figures by an occupational health program.

The Texas Medical Association had provided prior medical appreciation and leadership in the field of industrial and occupational medicine. For the past 2 years, since creation of a Division of Occupational Health in the State Department of Health, Association committees have worked jointly in an expanding program. However, real control properly belongs with the physician, often the family doctor.

Occupational health involves governmental health agencies, management-provided industrial medical services, and medical care through private practices. The scope of each and their inter-relationships have been defined in recent actions by the American Medical Association, Association of State and Territorial Health Officers, and American Public Health Association. Certain professional policies have been challenged by some organized labor groups, and private practitioners as well as official health personnel need to have a clear understanding of these differing philosophies.

What has the Division of Occupational Health done in Texas since its establishment? Many physicians may not realize how many aids to their practices are available from the health department—to help them keep their breadwinner patients physically and mentally on their jobs and temperamentally suited to their work. An excellent occupational health library ensures physicians hundreds of modern references along with more than 30 periodicals.* The Division of Occupational Health last year distributed more than 155,000 bulletins of guidance, professional advice, and regulations—more than 1,100,000 pages. Its professional medical, engineer, and nurse staff participated in many major university programs

**Texas State Department of Health, OH-19-1, Occupational Health Library, Austin, April, 1958.*

and professional conferences. It developed for State Board of Health approval regulations covering radiation safety, safe concentrations of toxic materials in industrial environments, safe health standards for working environments, and safe standards for industrial homework. A statewide air pollution appraisal was made. Information on poisons and poison control centers was distributed widely. Unusual attention was given by the division, the Texas Agricultural Service, and the Texas Medical Association to poisonous insecticides. Prevention of occupational deafness and preservation of occupational vision were added to the program. Consultation given as requested from many areas and staff visits through local health departments brought direct aid to many citizens.

Encouraging efforts to supplement those of the State Department of Health have been made by Dr. C. U. Callan's Texas Medical Association Committee on Rural Health and Doctor Distribution in collaboration with the Texas Agricultural Extension Service; Dr. V. C. Baird's Committee on Industrial Health with industrial medical, nursing, industrial nursing, and hospital association leaders; and Dr. Herbert C. Allen, Jr. and his Committee on Nuclear and Atomic Medicine in relation to radiological health.

Much remains for all of us to do. Several larger industries have excellent programs now. But Texas will have adequate occupational health only as we, along with employers, expedite the appropriate services required by employees in smaller industries (less than 250 employees), household workers, and agricultural workers. Perhaps more difficult is occupational health for employees engaging in trade, construction, transportation, and utilities. Then, too, how can we visualize programs for self-employed, for governmental, hospital, and educational institutions?

We can achieve proper coordinated performances between governmental, industrial medical, and private practice elements of the occupational health program in Texas. The health department and Association committees can be called on for help, but the function must succeed locally. The individual physician controls our prospects of success.

—W. L. WILSON, M.D., Austin.

♦ Dr. Wilson, State Department of Health, Austin.

SOME CHANGES IN THE WAY PEOPLE SPEND THEIR MONEY

More Dollars Go for These Things

Out of each $1,000 of consumer spending—	In 1940	Now*
Groceries	$208.00	$234.00
Telephone, telegraph service	8.60	13.10
Hospital care, health insurance	9.60	17.30
Private schools and colleges	6.70	10.40
Boats, planes, sporting goods, toys	7.80	11.30
Auto repairs and service	9.00	12.30
Radios, TV sets, records, musical instruments	6.90	9.10
Home appliances	12.30	16.20
Jewelry and watches	5.80	8.50
Foreign travel	2.40	6.10
Betting on horse races (Pari-mutuel net receipts)	.77	1.55
Radio and TV repairs	.45	2.80
Airline travel	.25	1.80

Fewer Dollars Go for These Things

Out of each $1,000 of consumer spending—	In 1940	Now*
Liquor	$ 50.10	$ 35.00
Water	5.00	3.50
Tobacco	26.10	21.30
Footwear	17.60	14.70
Other clothing	85.60	66.70
Rent	57.80	37.00
Furniture	14.70	14.40
Drugs	8.80	7.10
Physicians, dentists	18.50	16.20
Funerals	7.20	4.90
Railroad fares	3.55	2.00
Books and maps	3.30	2.20
Tickets to amusements	12.60	6.70

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President's Page

"SPECTATORITIS"

DR. SMITH

Many cases of the disease "spectatoritis" have been reported in our county medical societies and in some it is becoming epidemic. All physicians should be on the lookout for it.

There seems to be a predisposition to spectatoritis. It finds its victims among those with a tendency toward lethargy—men of the "let George do it" outlook. It does not seem to be dependent upon a man's professional attainments, his ability to look after his patients, or his personality in general. The man who neglects to vote is a likely victim.

There is some connection between spectatoritis and our modern mode of living. The disease was largely unknown in the early days, when all citizens got together at town meeting to settle common issues. As the nation became more thickly settled, it became convenient for citizens to select others to represent them at the councils of government. Men became increasingly dependent on specialists for food, clothing, and services. They found it easier to sit in the stands and watch others play the game.

Spectatoritis is not likely to be revealed by a physical examination. The victim does not break out in spots; he does not run a fever. Any change that results is emotional, involving a shift of attitude. The eyes are likely to take on a sleepy expression at meetings. The victim is likely to lose some of his enthusiasm. The new lethargy may result in an inclination to obesity, although not always.

Slight or no physical reaction makes diagnosis difficult. Nevertheless, there are definite symptoms. The medical society that suffers an outbreak of spectatoritis starts to slow down perceptibly. It becomes like the hospital set up by the Reds in North Korea. A Chinese soldier returned from the front with a slight wound and reported to the hospital for treatment. He found two doors, one marked "Officers" and one marked "Troops." He went through the latter door and found two more doors, one marked "Slightly Wounded" and the other "Seriously Wounded." He went through the door marked "Slightly Wounded." Two more doors confronted him. One was marked "Party Members" and the other "Nonparty Members." He went through the

door marked "Nonparty Members" and found himself in the street again. When he returned to his unit, his friends asked what the hospital had done for him. "Nothing," he replied, "but the organization was perfect." The county medical society afflicted with spectatoritis will retain a perfect organization but will do nothing for its community or for American medicine.

Let me describe an outbreak. The president of a county society started to appoint committee chairmen. Each member he approached protested, "This is important work, and the society should do it; however, I don't have the time." The president pointed out that each member should accept any office or committee assignment offered, that these places should be passed around so that all might have the experience and perform the labor. He told them what a bad society would result when a few run its affairs year after year. But it was no use. The society now has 30 drones and 10 workers. The drones occasionally lift their hands to applaud a guest speaker, but they do not lift a hand to help their society.

This is about the way spectatoritis affects a man. It saps his initiative. It makes him satisfied with his status quo and unwilling to disturb the serenity of a do-nothing existence. He is willing to be in the society, but not of it.

Treatment of an acute case of spectatoritis is not easy. Since the disease is more emotional than physical, it requires therapy designed to produce a change in outlook—a new feeling of responsibility. The prognosis depends on the kind of physicians who surround the victim. For a cure, the physicians must impress upon the victim the need of his cooperation and energy.

Physicians are bound together in their societies as one strong unit to accomplish things which the individual cannot achieve. They are like a powerful steel cable. A strand of approved, tested steel—the individual physician—is bound with similar strands into a strong rope —the county society—and the rope becomes a part of the mighty cable —the state, national, and world medical associations. These associations—the cable—are doing the big things, but only through their individual strands is this possible.

Let us stop being spectators. Let us play the game to the fullest.

Howard O. Smith M.D.

Problems in Urological Differential Diagnosis

ELMER HESS, M.D.;
RUSSELL B. ROTH, M.D.;
ANTHONY F. KAMINSKY, M.D.; and
HAROLD J. McLAREN, M.D.

Erie, Pennsylvania

Dr. Elmer Hess, chief of the Urological Clinic and chief of staff, St. Vincent's Hospital, presented this paper at the Texas Medical Association General Meeting April 22, 1958, at Houston. His co-authors are all members of the staff of the Urological Clinic.

The authors illustrate, citing a number of urological cases, the errors and damaging results that may occur when there is inadequate communication between the referring physician and a consulting specialist. The importance of a good history and physical examination plus giving the specialist all information concerning the patient is stressed.

THE differential diagnosis between urological conditions and other pathological entities is possible only if the physician is conscious that there is a urogenital tract and that it is important. In an experience with these problems that has covered many years, we have found that there are many medical men who are not urologically minded. One does not have to be interested particularly in the urogenital system to be conscious of the fact that the best service can be rendered only by a conscientious attempt to evaluate symptoms and findings and to pinpoint them. We repeatedly have made the comment that the specialist should be the right hand of the generalist and that most of the problems which present themselves can be and should be solved by the well trained general practitioner. The specialist, in the best interests of the patient, should spend his time in the tedious diagnostic and treatment problems in his particular field, which the physician has neither the time nor the training to carry out. If this attitude were adopted by the profession, there would be no room for significant differences of opinion between the generalist and the specialist. Unfortunately, many of our good general medical friends are as much responsible for these frictions as are the specialists. The specialist's role in the treatment of patients is far more effective if there is complete cooperation with the family's usual medical attendant. This, of course, demands that, for the most part, patients should be referred to the specialist with a working diagnosis, which means that a differential diagnosis has been carefully considered so that the patient may be referred intelligently to the proper specialist. Ideally, of course, the referring generalist remains in fundamental charge of the complete patient, with the specialist in a subsidiary role.

"APPENDICITIS"

A number of years ago, one of our surgical friends operated on what he thought was an acutely diseased appendix. The patient had all of the signs of a moderate peritonitis on the right side. A normal appendix was removed, and the surgeon, a conscientious fellow, was mystified completely until 48 hours later, when his patient developed an acute epididymitis on the right side. A careful history, even without a proper physical examination, would have made him suspicious that he was dealing with an acute right vasitis which easily can simulate an acute appendicitis.

The differential diagnosis between ureteral calculi and acute appendicitis will be made seldom unless the physician who first sees the case is oriented urologically. We have seen an unjustifiable number of instances in past years wherein the appendix has been removed first and the offending stone found only later on. For years we have advocated the plain abdominal roentgenogram in all suspected acute appendicitis while waiting for the operating room to be readied for the surgery. However, even in the presence of a known stone in the right ureter, I would rather see a normal appendix occasionally removed than to have one rupture. A plain film of the abdomen is more important than a urinalysis or a white cell count in the differential diagnosis between right ureteral calculus and appendicitis.

One case of appendicitis was rather interesting. The patient, a middle aged man, had been sent to us with the diagnosis of right ureteral calculi. The referring physician stated in his note that since this man had had his appendix removed, he was pretty sure of his diagnosis, and he had already had made a film of the abdomen which he thought showed the stone. The history and physical examination, however, made us feel that the lesion was intraperitoneal rather than retroperitoneal. A surgical consultation resulted in an abdominal operation, and a very acutely diseased appendix was removed. Hindsight revealed that the alleged appendectomy had been performed

by a cultist, and the previous incision had been made only through the skin.

We once saw a walled-off appendiceal abscess, undiagnosed and untreated, which ruptured eventually into the right ureter. The patient passed gas during urination. This is an important observation, since it is not uncommon for a diverticulum of the colon to attach itself to the urinary bladder and to rupture into the bladder with the formation of a vesicocolic fistula. Feces may be voided, but gas almost invariably will be passed through the urethra during urination. When this subjective symptom is found, diligent search is necessary to find the fistula. In this particular case, the fistula between the appendiceal abscess and the ureter had been present, with only vague abdominal discomfort, over a long period of years. Finally, the abscess tract opened up in the cecum with the passage of gas through the tract. At the operation to close the fistula, the location of the retrocecal-destroyed appendix was very evident. The old appendiceal stump was removed as in an appendectomy and the opening in the ureter was closed easily. It must be remembered always that such a fistula can develop between bowel and ureter, although the bladder to bowel communication is far more common.

In another case, one of our most remarkable, the family physician saw a 5 year old boy with abdominal pain. He feared appendicitis and operated promptly, only to find a normal appendix. He then reflected on the past history of this child who, at the age of 1 year, had been shown to have bilateral Wilms' tumors of the kidneys. He inspected or palpated the region of the right kidney and found a large hemorrhagic mass. This is not the place for the details of this exceptional case, but we can report that the Wilms' tumor on the left, which was the original mass that brought the child to us, had been treated with a small amount of roentgen ray, and all treatment had been discontinued after demonstrating a definite right renal mass which was proven by biopsy also to be a Wilms' tumor. We had presumed the child dead when we were called by the physician 4 years later to be told about his appendectomy. We did a radical nephrectomy on this right kidney after it failed to respond to a full course of roentgen-ray therapy, and today, 5 years later, the lad is well, husky, and devoid of any sign of disease in his original tumor distorted left kidney.

Lest we be accused of sounding "holier than thou," let us admit that we once did a prostatectomy on an elderly gentleman, who, on his seventh postoperative day, began to be nauseated and to complain of abdominal pain. We passed this off as a postoperative complaint of little consequence and literally watched his appendix perforate without recognizing it. It was no minor oversight. The ensuing peritonitis was more than he could withstand, and the patient died, an experience which has left us with the knowledge that our judgment can be as faulty as the next fellow's.

TUBAL AND PROSTATIC DISEASE

A physician referred his wife to us a number of years ago with the diagnosis of right ureteral calculi obstructing the ureter with a huge hydronephrosis. The pain was excruciating. Physical examination revealed a large mass high in the right side of the abdomen, exquisitely tender. There was no elevation of temperature, and the patient had been well until the attack. She had already lost her appendix. A plain film of the abdomen revealed no stone. Intravenous urogram revealed a normal right kidney. Surgical consultation and subsequent laparotomy revealed an ovarian cyst twisted on its pedicle. The ovarian cyst rode high in the right side of the abdomen and had fooled completely the referring physician because of the location of the mass. The severe pain in this case made us suspicious.

This case also recalls experiences that occurred much more often in the old days than they do today, but even now, every once in a while, an acute tubal infection will give us much diagnostic concern. Many an acute tubal infection was operated upon and many an ovary in the old days was called cystic and removed when the real diagnosis was a stone in the ureter or a kinked ureter with or without an acute hydronephrosis. I believe the policy today is not to operate upon acute tubal infections while they are "hot" and the modern well trained surgeon or gynecologist has been trained not to mistake unruptured graffian follicles for cystic disease of the ovary. We strongly believe that every patient undergoing a urological survey should have a careful vaginal examination by the urologist, and if suspicious gynecological findings muddy the diagnostic waters, an immediate gynecological consultation is imperative.

A careful physician referred to us an elderly man with prostatic obstruction. The history was interesting. He had been voiding about every 3 hours by day and at least twice at night. He had become extremely uncomfortable and the physician had made a diagnosis of cardiovascular-renal disease with ascites and had tapped him daily for about 2 weeks before he realized that he had been tapping a full bladder which extended to his ensiform process. This is 1 of 2 cases of this nature. Do not criticize the physician too much for not immediately recognizing the fact that this was a huge bladder plus a huge prostate plus a comfortable overflow incontinence. There are a number of older men who never dream, and neither do their physicians, that they have obstructing prostates. This is particularly true when, per rectum, the gland does not seem large. A small prostate can be

obstructive, and a prostate which feels normal to the examining finger may have an obstructive intravesical enlargement.

The symptomatology of prostatism is not limited to the urinary tract. Some obstructing prostates cause little or no subjective urinary discomfort. However, in men over 60 the prostatic obstruction often causes symptoms which are misleading. These cases may be divided readily into 4 general groups—those exhibiting cardiovascular symptoms, hypertension, gastrointestinal symptoms, and neurological and psychiatric symptoms.

We have seen patients with obstructing prostates who have been treated for one or more of these conditions for long periods of time by well trained men. Because of a lack of genitourinary symptoms, they have not been suspected of any prostatic obstruction until acute retention has developed or until the doctor has done a rectal examination and has found an enlargement of the gland. The proof of this is the fact that many of the symptoms referred to the other tracts disappear promptly upon the relief of the urinary obstruction. This once again emphasizes the fact that no physical examination is complete without the digital examination of the rectum. A number of years ago, one of us was asked to discuss a paper on pathological fractures in an orthopedic meeting. During the reading of the paper, a case was recited in which nailing the fractured neck of the femur had failed because the fracture was a pathological one due to metastasis from carcinoma of the prostate. The roentgenogram had been misinterpreted, and there was no record that any of the attending men had suspected the prostatic lesion until after the operation on the hip had been done by a competent orthopedist. After the failure, more bone studies had been made. Other bones showed suspicious lesions, and a urological examination revealed the prostatic carcinoma. We mentioned the fact that if a rectal examination had been made, the diagnosis at least would have been suspected. To our utter amazement, a prominent professor of orthopedics stated that he, himself, never did rectal examinations and that he would not be able to evaluate a suspicious prostate. This, we think, is wrong. Any physician should be able to make an adequate rectal examination, and although he may not be able to make a thorough diagnostic evaluation of what he feels, he certainly will be rewarded amply in many cases for his efforts. Every physician, whether generalist or specialist, should spend a little time learning what to expect from a digital examination of the rectum. My proctologic friends tell me that the vast majority of rectal lesions are within reach of the examining finger. Certainly, it is not difficult to learn how to tell the difference between a large smooth hypertrophy of the prostate and the hard nodular gland suspicious of malignancy. Recently, Hudson, Crane, and others have produced evidence that routine biopsy of troublesome prostates will disclose an unsuspected number of potentially curable carcinomas.

OTHER WRONG DIAGNOSES

Urologists have long preached that painless hematuria requires immediate investigation by complete urological survey. This constant preachment has begun to produce the desired results, and if this increased suspicion may be coupled with an enthusiasm for careful history taking and physical examination, it will represent progress indeed. A number of years ago, a generalist referred to us a case for confirmation of his diagnosis of bladder endometriosis. He had been unable to make the diagnosis by pelvic examination, but he was clever enough to ascertain through the history that the patient's massive painless hematuria was due to the rare extension of the disease to the urinary bladder. He noted that only during the menstrual period did this woman bleed. Cystoscopic examination revealed that there was no tumor of the bladder, but that the lesions present were typical of endometriosis. The patient was referred to a gynecologist, and since she was near the end of her productive life, bilateral oophorectomy cured the condition.

Although it is true that in nearly 90 per cent of the cases showing painless gross hematuria one can demonstrate new growth in the urinary tract, it is still important to get a good history and a good physical examination, for there are other conditions that cause urinary bleeding. It is helpful also to the specialist to have the referring physician give him a good history and report of a physical examination with a working diagnosis. For example, a young woman was once sent to us by her family physician because she reported to him that there was a lot of blood in the toilet bowl after urination. He regarded further history as unnecessary, and sent her to us forthwith. We compounded the error by carrying out excretory urography and cystoscopy without stopping for an adequate history and physical examination. It was only after finding no evidence of trouble in the urinary tract that we learned, through history and pelvic examination, that she had been pregnant without realizing it, and had had a miscarriage as her source of bleeding.

The genital tract must not be slighted when differentiating the causes of lower abdominal pain. Recently, we were asked by one of the general surgeons to see a 28 year old man because his "belly" distress did not seem to "add up" to appendicitis. He had sudden onset of right lower quadrant pain, temperature 101 F., white blood count 12,000, and the urine

contained only an occasional white blood cell. Further examination revealed tenderness along the upper portion of the right vas, and rectal palpation revealed marked tenderness of the seminal vesicle. Treatment directed at the vesiculitis and vasitis cured the patient.

Chronic, silent conditions of the urinary tract may be misleading. A 54 year old man had been complaining of pain in the upper abdomen, especially after eating or drinking large amounts. He had been on special diets and antispasmodics for 6 years. He was sent to the Urological Clinic, St. Vincent's Hospital, because of an incidental stricture of the urethra. While he was being studied urologically, a silent, large left hydronephrotic "sac" about the size of a football was discovered. The removal of this diseased organ relieved all of his symptoms, and he was rehabilitated completely.

The kidney must be considered in the so-called acute abdomen as well as in the chronic conditions, as illustrated by a 50 year old housewife who had been perfectly well but collapsed one evening while preparing the family dinner. She arrived at the hospital in shock, with right upper abdominal pain and tenderness. Urinalysis was negative. Along with pain and upper abdominal tenderness, pallor and shock were prominent signs. Volvulus and intussusception were considered. The abdomen was opened, and a huge right retroperitoneal hematoma was found. Further exploration revealed a hematoma of the kidney apparently of spontaneous origin.

A similar situation developed in a man after "bumping" his abdomen on a machine while at work. This man was suspected at first of a possible ruptured viscus. More detailed roentgen-ray studies revealed perirenal "shadows." This was found to be perirenal hemorrhage due to the rupture of a renal tumor. The tumor was extremely small and would not have been discovered for a long time if it had not been for the accident.

An undescended testis may cause diagnostic confusion, especially if one has overlooked its absence from the scrotum. Even the intra-abdominal epididymis may become acutely inflamed, adding to the difficulties in the differential diagnosis of right lower quadrant pain with fever and leukocytosis. We know of at least one surgeon who was chagrined to find this as the cause for the "acute appendicitis" which he had diagnosed preoperatively. There is no moral to this other than the obvious fact that careful palpation of the scrotal contents is a part of the complete physical examination.

Despite the accessibility of the scrotal contents, differential diagnosis here may be difficult. There are certain rules of thumb. The true hydrocele transilluminates clearly and does not fluctuate much in size from day to day. If the transilluminable mass does tend to be small or absent in the morning and large by the end of the day, a hernial communication should be suspected. Testicular tumors tend to have a heavy feeling when large, and rather rarely involve the spermatic cord, whereas the enlargement of epididymitis seems less bulky and there is usually an associated thickening and tenderness of the cord above the mass. Entirely painless masses are likely to be tumors, but a tumor may be very tender indeed, owing to internal hemorrhage, necrosis, and the like. A torsion of the testis in its early phase is excruciatingly painful and usually is associated with cremaster spasm, which holds it high in the scrotum. Later, after the death of tissue secondary to the infarction, the twisted testis becomes painless. A collection of hydrocele fluid may develop as a complication of trauma, tumor, or infection, but it is easy to aspirate the fluid to permit more accurate palpation, as well as to provide material for microscopic examination and culture.

One cannot believe everything one sees. An interesting example of this goes back many years when a friend of ours asked us to see an ex-pugilist. There was a large palpable mass in the patient's left flank —no other subjective or objective symptoms. The mass was discovered entirely by accident. Several physicians had seen the patient and completely had missed the diagnosis. This was an old ruptured kidney with a marked pyonephrosis with complete destruction of the kidney from infection. The kidney had never been considered as the origin of the mass because the urine had been entirely normal. It had not occurred to anyone that the patient could have a pyonephrosis with normal urine. The answer was obvious—the left ureter was blocked completely and the only urine accumulating in the bladder was the normal urine from the right normal kidney. One cannot rule out the kidney as the source of a patient's symptoms on the basis of a normal urine.

Another case involved one of the outstanding young surgeons of our community. He was called to see a young man who had sustained considerable abdominal trauma, and the question was whether or not there was a ruptured viscus. The surgeon felt that conservatism was indicated, and the acute emergency passed. Some months later he again saw this patient, complaining of abdominal fullness. There was a palpable epigastric mass. This increased in size during a few weeks of observation. Finally, with a preoperative diagnosis of possible pancreatic or mesenteric cyst, an exploratory operation was undertaken. Had a preliminary intravenous urogram been made, almost certainly it would have suggested the huge hydronephrosis which was found, and it would not have been necessary to summon the urologist on an emergency basis to help with the nephrectomy.

HERNIA

Sometimes the differential diagnosis between urological conditions and the various types of hernia may be confusing. On two occasions, we have been called in to see patients who have been operated upon for direct inguinal hernias. Following the operations in both instances, urinary leakage occurred in the convalescent period. In both cases, a portion of the urinary bladder had been in the hernia and had not been recognized. In one case, a portion had been excised and was recognized as bladder in the laboratory. In the other, the bladder wall had been stitched and caught in the sutures eliminating the sac. In each instance, a competent surgeon had had this happen to him. In these cases, good results were obtained by going in and closing the opening into the bladder, but the patient had to have a second operation and undoubtedly the surgeon was embarrassed considerably.

Another interesting case was diagnosed prior to the original surgery. A patient was referred to us with aggravating symptoms of frequency and urgency of urination only while up and about and at work. The symptoms immediately disappeared when the patient reclined or was in bed. He also had an enormous hernia which did not particularly disturb him. It was out during the day, but disappeared at night. A careful urological study revealed a normal urological tract except for the suggestion that the fundus of the bladder seemed to be distorted and fixed toward the right side, the side of the hernia. The patient then was sent to a competent surgeon with the warning that the bladder apparently was incorporated partially in the hernia. As a result, there was no injury to the organ, and when the patient recovered from his surgery, his frequency and urgency were relieved completely.

One always must consider a Richter's hernia in cases of pain in the lower abdomen. The differential diagnosis is often difficult, and we have seen a Richter's hernia diagnosed as calculous disease. The symptoms should be remembered. When just a portion of the lateral wall of the bowel gets caught in the internal ring, there may be diarrhea instead of complete obstruction. The tender spot is the internal ring, and often these cases will go unrecognized for several days before the physician recognizes that he has a strangulated portion of the intestinal wall caught in the ring. The roentgenogram often is of little value in this condition. In our only experience with this condition, we were fooled completely for several days thinking that we were dealing with a nonopaque calculus in the lower left ureter. Surgical consultation after repeated negative urological studies indicated some form of intestinal obstruction, and operation revealed the diagnosis. The gangrenous side wall of the hernia demanded a bowel resection, but, fortunately, the patient made a good recovery.

NEED FOR COMPLETE INFORMATION

During the preparation of this paper, an unusual thing happened at the Urological Clinic. A gentleman was sent to us with acute urinary retention. As he was in agony, a Foley bag catheter was slipped into his bladder so that he could have relief until he could get a bed. After an hour on the cart waiting for his room, he had a severe attack of pain in the epigastrium and went into a state of mild shock. An immediate film of the abdomen revealed free air under his diaphragm. If the referring physician had known the patient had a gastric ulcer, he did not inform us. An immediate surgical consultation and fast emergency surgery demonstrated the perforation, which was closed. The wound drained, and the patient is making an uneventful recovery. He still has his hypertrophied prostate and his retention catheter.

This case illustrates an important point. The referring generalist should send or give the specialist all of the information possible concerning the patient. Again this emphasizes the importance of an accompanying good history and physical examination. Everyone should be able to do both. The art of taking histories and doing physical examinations must not become a lost art. The laboratories can only supplement the diagnostic value of the patient's story and a physician's efforts to make a good physical examination. When physicians are too busy to do these things, they are too busy to practice good medicine successfully.

SUMMARY

Consulting specialists are able to fulfill their roles best through the cooperative teamwork of modern medical care when the referring physician has done careful initial screening based on a good history and a judicious physical examination. This primary role of the generalist is not only the best assurance of competent diagnosis and treatment, but is the outstanding bulwark against the indefensible costs of unneeded tests, unnecessary therapy, and dangerous delay. A few illustrative cases have been cited showing opportunities for discrimination in respect to the differential diagnosis of urological conditions.

♦ Drs. Hess, Roth, Kaminsky, and McLaren, Urological Clinic, St. Vincent's Hospital, Erie, Pa.

An estimated 10,000,000 children under 16 have some form of allergy and 2,500,000 have major respiratory allergies requiring treatment, according to the publication "Patterns of Disease," prepared by Parke, Davis and Company.

Parathyroid Syndromes and Calcium Metabolism

ARTHUR GROLLMAN, M.D., Ph.D., F.A.C.P.
Dallas, Texas

DISORDERS of the parathyroid glands are attracting increasing interest since it is now recognized that they occur with much greater frequency than has hitherto been assumed. Moreover, despite their relative rarity, the recognition of parathyroid disturbances is of vital importance, since, if overlooked, they lead to a long period of disability which may ultimately result in death; whereas, treatment by the available medical and surgical procedures allows complete recovery, control of the symptoms, and avoidance of irreversible damage to the organism.

Symptoms of parathyroid disease are often, at least in the earlier stages, relatively nonspecific and accordingly are apt to be attributed to psychoneurosis, allergic reactions, or other functional disturbances. However, certain features of parathyroid disease, elicitable by the history and physical examination, should point suspicion to the existence of disease of these organs. Laboratory procedures are available to permit a definitive diagnosis before embarking on a course of therapy. Disturbances of the parathyroid glands should be suspected when there appear early nonspecific symptoms which reflect alterations in the irritability of the nervous system resulting from hypercalcemia or hypocalcemia. Such nondescript symptoms as fatigue, polyuria, chronic constipation, mental depression, hyporeflexia, gastrointestinal disturbances, peptic ulcer, pancreatitis, and anemia in addition to renal lithiasis and the well-known skeletal deformities should suggest the possibility of excessive parathyroid secretion. On the other hand, hyperreflexia, epileptic seizures, ectodermal disturbances, a positive Chvostek or Trousseau sign, and gastrointestinal disturbances with anorexia, vomiting, and chronic hiccough should suggest possible parathyroid insufficiency.

It is not surprising that with the small size and inconspicuous nature of the glands, their very existence was overlooked for so long a time and that disease of the organs as a clinical syndrome dates only from the last three decades.[7] As time has elapsed, however, more and more instances of a disorder of these glands are being encountered and recognized and adequate treatment instituted.

PHYSIOLOGY

The parathyroid glands are concerned with the maintenance of normal calcium homeostasis[10] and with the exchange of inorganic phosphate in the body. Since these ions are so intimately associated chemically, the two must always be considered together in evaluating the observed biochemical state of the extracellular fluid.[7] Excessive parathyroid activity results in an elevation in the serum calcium and reduction in inorganic phosphate; deficient parathyroid activity results in the opposite effects, namely, a subnormal calcium ion and an elevated inorganic phosphate content of the extracellular fluid.

The alteration in the ionic calcium content of the serum and extracellular fluid affects the irritability of the cells generally and the nervous system in particular.[9] Hypocalcemia induces an increased reactivity of the nervous system as evidenced in the hyperreflexia, tetany, and convulsions of hypoparathyroidism; hypercalcemia causes a depression of the nervous system with hyporeflexia, a reduced QT interval in the electrocardiogram, and the decreased motility of the gastrointestinal tract, characteristic of hyperparathyroidism.

In addition to their effects on nervous and cellular irritability, parathyroid disorders result in disturbances of the bones and extraskeletal tissues. Thus the hypercalcemia of hyperparathyroidism may be accompanied by extraskeletal calcification which is demonstrable particularly in the kidney, lungs, blood vessels, and other tissues and contributes to their dysfunction. Thus, the ulceration of the gastrointestinal tract[6] and of the skin over the lower extremities[1] and the pancreatitis,[3] which has been noted in adenoma of the parathyroids, may be attributed in part at least to the deposition of calcium in the soft tissues.

The parathyroid hormone also affects the reabsorption of phosphate by the renal tubule.[10] It was believed formerly that this was its primary action and that the effect on the serum calcium was secondary to the excretion of phosphate. However, the error of this view is now recognized; the parathyroid hormone exerts a direct action on the bones.[8] As the result of the action of the hormone on the kidney, there is a decreased rate of reabsorption of phosphate by the tubules. The excessive secretion of calcium in the urine is probably secondary to the elevated serum calcium level.[10] The excessive passage of calcium and phosphate through the kidney in turn results in calcinosis of the renal parenchyma and the deposition of renal calculi.[7]

Hypoparathyroidism expresses itself by an increased irritability of the tissues and nervous system, patients

with hypocalcemia manifesting symptoms attributed usually to psychoneurosis, allergic reactions, epilepsy, and the like. In the adult, the striking features result from dysfunction of the gastrointestinal tract, so that anorexia, vomiting, and weakness are commonly observed. However, when the condition is prolonged, secondary changes occur, with dysplasia of the ectodermal tissues, widening of the dura lamina, and deposition of calcium in extraskeletal sites with calcification of the basal ganglions and deposition of calcium in the conjunctiva and cornea as seen in the slit-lamp. When hypoparathyroidism is extreme, hypocalcemia results in tetany which may be latent, as evidenced by positive Chvostek and Trousseau signs, or manifest, with carpopedal spasm, laryngospasm and epileptiform convulsions.

HYPERPARATHYROIDISM

Hyperparathyroidism, with an excessive secretion of the parathyroid hormone, is most commonly a result of adenomatous involvement of a single gland (82 per cent) or diffuse hyperplasia of the glands (9 per cent). Rarely, it results from multiple adenomas (4 per cent) or is associated with adenomas of the pancreas, adrenal, or pituitary glands (4 per cent). The incidence of hyperparathyroidism secondary to carcinoma of the parathyroid is less than 1 per cent.

Dr. Arthur Grollman, who is chairman of the Department of Experimental Medicine, University of Texas Southwestern Medical School, presented this paper at the University's Postgraduate Course on Metabolic Disorders, November 13, 1957, in Dallas.

Disorders of the parathyroid glands occur more frequently than has been thought heretofore. They may lead to a long period of disability and death unless treated by available medical and surgical procedures. Biochemical and clinical diagnostic methods, suggested treatment, and illustrative cases round out this presentation.

Long standing hyperparathyroidism was first associated with the widespread lesions of the bones with bone cysts, giant-cell tumors, and fibrous displacement of the bone designated as von Recklinghausen's disease of bone or generalized osteitis fibrosa cystica.[7] However, this classical form of the disease is rarely encountered now since the condition is recognized prior to the development of such devastating lesions. The disease should be suspected in patients with such nonspecific lesions as benign bone tumors, especially of the jaw, with generalized demineralization, collapse of the vertebral bodies, single or multiple fractures resulting from insignificant injuries, and severe deep boring pain. As a result of the displacement of the bone marrow, hyperparathyroidism occasionally may present itself with anemia as an outstanding finding.

The commonest presenting symptom of hyperparathyroidism is recurrent renal lithiasis. All patients with renal lithiasis, particularly if recurrent, should have hyperparathyroidism excluded, for otherwise irreparable damage to the kidneys and death in uremia will ensue. In addition to renal calculi, hyperparathyroidism may result in renal disturbances characterized by polyuria, polydypsia, inability to form a concentrated urine, and, rarely, diabetes insipidus of renal origin. These are presumably a result of nephrocalcinosis which may be evident in the roentgenogram.

Less commonly presenting symptoms of hyperparathyroidism are a result of functional disturbances of the pancreas, gastrointestinal tract, and nervous system. These are characterized by chronic constipation,[1] peptic ulcer,[6] pancreatitis,[3] chronic fatigue,[5] and mental depression.[7] An elevated serum calcium level results in decreased irritability of the cells, particularly of the nervous system, and is responsible for the hypotonia, muscular weakness, hypermobility of the joints, diminished reflexes, chronic constipation, abdominal distention with nausea, vomiting and other gastrointestinal disturbances, cardiac arrhythmias with a short QT interval in the electrocardiogram, easy fatiguability, mental depression, and other characteristic manifestations of hyperparathyroidism. Hypercalcemia is also attended by metastatic calcification which results in band keratitis with calcification at the sclerocorneal junction and calcification of the media of the blood vessels, particularly of the legs. The latter may cause ulcers and intermittent claudication. Calcification of the pancreas gives rise to pancreatitis, and calcification of the lungs, thyroid, and other tissues may alter the function of these organs.

Rarely, parathyroid intoxication may occur acutely, usually in patients with parathyroid tumors who manifest symptoms of peptic ulcer for which large quantities of milk, alumina gel, and other alkalinizing agents are administered. Dehydration, nausea, and vomiting may terminate in coma and death, if the condition is not recognized and treated.

Typical examples of hyperparathyroidism are illustrated by the following case reports:

CASE 1.—A 52 year old farmer suffered a fracture of the fifth metatarsal bone when striking his foot against a tractor. Roentgen-ray examination revealed a pathological fracture at the site of a bone cyst. The patient's past history was unrevealing except for chronic constipation, generalized gnawing pain of the legs, and chronic fatigue, none of which was of sufficient severity to demand medical attention. Physical examination was negative except for extreme hyperlaxity of the joints and diminution of the deep reflexes. Roentgenograms revealed generalized decalcification

of the skeleton with a finely granular and mottled appearance of the skull, a bone cyst in the shaft of the tibia, and the pathological fracture which was the cause of the patient's hospitalization. The serum calcium was 13.5 mg. per 100 cc.; the inorganic phosphate, 2.6 mg. per 100 cc. At operation, a single parathyroid adenoma near the upper right pole of the thyroid was removed. The remainder of the parathyroid glands appeared normal except for their small size. Following operation, there was a repair of the skeletal defects and marked improvement in the patient's general feeling of well-being.

CASE 2.—A 25 year old nurse had been subjected to nephrostomy twice during the previous year because of renal stones, first of one kidney and 6 months later of the contralateral one. Three months later calculi were present in both kidneys. Physical examination was negative except for hyperlaxity of the joints. A roentgen-ray survey of the skeleton was entirely negative. The patient gave a history of consuming a quart of milk daily. The serum calcium was 14.5 mg. per 100 cc.; the inorganic phosphate, 2.0 mg. At operation a single parathyroid adenoma was found and removed, following which the patient made an uneventful recovery.

These 2 cases illustrate the most commonly observed manifestations of hyperparathyroidism, namely, pathological fractures with skeletal changes and renal calculus formation. However, neither of these may be the predominant manifestations of the disease.

HYPOPARATHYROIDISM

Hypoparathyroidism as a complication to thyroidectomy is readily suspected, but its occurrence as a result of congenital absence or failure of parathyroid function is more likely to be overlooked. In the former the appearance of paresthesia, circumoral numbness, and a positive Chvostek or Trousseau sign render the diagnosis obvious. It is in the congenital or so-called idiopathic types of hypoparathyroidism of unknown etiology that the symptoms may be misinterpreted and the condition may remain unrecognized until the appearance of such consequences of prolonged hypocalcemia as lenticular cataract, ectodermal dysplasias, convulsive disorders, and other evidence of central nervous system dysfunction.[4]

Typical examples of hypoparathyroidism as seen in the adult are illustrated by the following case reports:

CASE 3.—A 50 year old, recently widowed woman had been seen in several clinics and by many physicians over a period of 10 years with various symptoms which had been variously diagnosed as "psychoneurosis," hypoglycemia, and adrenal, thyroid, and pituitary insufficiency. Her principal symptoms consisted of anorexia, nervousness, and periods of hiccoughing which were precipitated by emotional disturbance. These usually responded to prolonged rest and the administration of sedatives. Laboratory examination revealed a serum calcium of 7.6 mg. per 100 cc., an inorganic phosphate of 5.5 mg., with no evidence of renal insufficiency. Under medication with dihydrotachysterol and calcium gluconate (orally) the abnormal chemical findings reverted to normal, and the patient has remained well during the past 8 years that she has been under treatment.

CASE 4.—A 15 year old girl had a history of gastrointestinal disturbances and periodic attacks of vomiting which began during infancy. At the age of 6 she had an attack of diarrhea which was attributed to amebiasis, for which she was treated. Following this, she began to have epileptic seizures. Despite large doses of dilantin and phenobarbital, she was still having convulsions which occurred particularly during the night and which required constant attendance. Incipient cataract formation had been noted at age 14. Menarche had appeared at the age of 13, but the menstrual periods were irregular and infrequent.

Physical examination revealed an underdeveloped girl who appeared to be about age 12. There was striking dystrophy of the finger nails, toenails, and teeth. The nails were brittle and thin and the teeth markedly carious and in many cases completely devoid of enamel. The latter finding was particularly unusual since the patient had spent her entire life in Deaf Smith County, Texas, notable for the high fluoride content of its soil and for the lack of dental caries among its inhabitants.

A roentgenogram of the skull revealed calcification in the area of the basal ganglions. Laboratory studies revealed a blood serum calcium of 4.0 mg. per 100 cc. and an inorganic phosphate of 12 mg. per 100 cc., which were corrected with dihydrotachysterol. The patient showed remarkable improvement, with cessation of the convulsions even after withdrawal of all anticonvulsive therapy, the institution of the normal menstrual cycle, and general improvement.

These patients illustrate some of the bizarre manifestations of chronic hypoparathyroidism, the attendant disabilities when the condition is not recognized, and the excellent response to therapy. Neither of the cited patients had undergone thyroidectomy. The first patient's disorder was probably a result of atrophy of the parathyroid glands during adulthood; the second patient may represent an instance of congenital hypoparathyroidism or so-called idiopathic hypoparathyroidism developing in early childhood.

DIAGNOSIS

Although the clinical history may suggest the possibility of parathyroid disease and the physical examination offer strong support for the suspicion of the existence of such a disturbance, laboratory studies based on roentgenological and biochemical examinations establish the diagnosis. Alterations in the skeleton may vary from the generalized demineralization and destructive lesions of von Recklinghausen's disease to minor degrees of demineralization limited perhaps to the subperiosteal areas of the phalanges, or may be completely absent.

Most patients with parathyroid dysfunction exhibit deviations from the normal levels of the calcium and inorganic phosphate of the serum. However, in many cases the biochemical deviations from the normal are not significant, or the observed changes result from renal insufficiency or other disorders accompanied by changes in calcium or phosphate levels.

In order to evaluate parathyroid activity, several special tests have been devised. The calcium tolerance test, in which a calcium salt is infused over a period of 4 hours and the rise of the serum phosphate and the rate of urinary phosphate excretion are determined, has proven to be of doubtful value since a normal response is often found in hyperparathyroidism.[2, 5, 6, 10] Much more reliable is the determination of the calcium excretion after the patient has been subjected to a low calcium diet (135 mg. daily) by exclusion of dairy products, breadstuffs, cereals, and other foods high in calcium content and by the limitation of meat intake. Under this regimen a urinary calcium loss greater than 150 mg. daily after 3 days on the diet is suggestive of hyperparathyroidism. The effect of a low phosphate diet on the serum inorganic phosphate and its rate of excretion by the kidney is also useful in equivocal cases.[2]

The most valuable procedure for use in doubtful cases is the determination of the tubular reabsorption of phosphate (TRP) defined according to the formula:

$$TRP = (1 - \frac{UP \times SC}{UC \times SP})\ 100$$

in which, UP = urinary phosphate, UC = urinary creatinine, SC = serum creatinine, and SP = serum phosphate. This test may be carried out in a simplified form by collecting the urine during the night and taking a blood sample at the end of this period[5] or by administering 500 ml. of water in the fasting state (after emptying the bladder), collecting the urine and blood 1 hour later, and determining their creatinine and phosphate content.[6] A TRP of 82 per cent is considered to be within normal range but most patients will have markedly lower values. The response of the TRP to phosphate restriction also has been utilized.[2] A TRP of 90 per cent or more occurs in normal subjects; of 85 per cent or less in patients with hyperparathyroidism.

Determination of the tubular reabsorption of phosphate as outlined, though helpful in many cases, is not always reliable.[5] Care also must be taken to exclude such conditions as osteomalacia, sarcoid, multiple myeloma, the milk-alkali syndrome, vitamin D intoxication, a crisis of adrenal insufficiency, berylliosis, acute osteoporosis, Paget's disease with fracture and immobilization, Hodgkin's disease, hypernephroma, and other malignant lesions of the bones, which are at times accompanied by hypercalcemia. The special features of these diseases usually render their differentiation from hyperparathyroidism possible.

TREATMENT

Treatment of hyperparathyroidism consists in the surgical ablation of the overactive tissue. The relatively small size of the affected glands, their ofttimes aberrant location, the alterations in size and appearance of the normal glands, and other factors require special surgical skills.[3, 5, 6] Special postoperative measures to avoid potentially fatal hypocalcemic reactions are also essential.

Except in acute parathyroid insufficiency where the injection of calcium salts and parathyroid hormone may be required temporarily, the treatment of hypoparathyroidism involves substitution therapy with calciferol (vitamin D_2) or dihydrotachysterol (A.T. 10) with supplementary oral calcium and a reduced phosphorus intake (aided by the administration of aluminum hydroxide), when necessary.[9] Careful adjustment of dosages is necessary to ensure adequate substitution therapy and the avoidance of the potential dangers of hypercalcemia.

SUMMARY

Parathyroid disorders are less rare than was formerly believed and must be kept in mind as potential causes of a variety of nonspecific disturbances as well as of the classical manifestations associated with disease of these glands. Biochemical procedures permit establishment of the diagnosis with certainty in most cases; available surgical and medical measures offer gratifying therapeutic correction of the otherwise debilitating and often fatal consequences of parathyroid disease.

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♦ Dr. Grollman, Department of Experimental Medicine, University of Texas Southwestern Medical School, 5323 Harry Hines Blvd., Dallas 19.

Manifestations Of Small Bowel Tumors

MACK F. BOWYER, M.D.

Abilene, Texas

TUMORS of the small bowel no longer can be considered rare although they are still rather uncommon as compared to lesions in other parts of the gastrointestinal tract. They are quoted by Pollock[21] as occurring 1 to 100 as compared to lesions in the stomach and 1 to 40 as compared to those in the colon.

In 1948, Singleton and Moore[28] noted reports of at least 535 cases of lymphosarcoma of the small bowel. In 1951, Pridgen[22] collected 550 cases of carcinoma involving the jejunum and ileum alone.

Weibel and co-workers[33] reported 165 cases of small bowel tumor from the Los Angeles County Hospital (covering a 16 year period) of which 100 were malignant. Of these adenocarcinoma accounted for 51 per cent, sarcoma 31 per cent, carcinoid 17 per cent, with 1 per cent being miscellaneous others.

Finally River and his group[23] reported an exhaustive study in 1956 on a collected series of 1,399 cases of benign tumors of the small intestine (exclusive of 77 cases in the Mayo series). The main problem seems to be emphasized by the fact that in 1,014 of these cases diagnosed at operation, the correct preoperative diagnosis had been made in only 79 instances. Olson, Dockerty, and Gray[19] reported on 77 cases (benign tumor) in which almost two-thirds of those studied were diagnosed or suspected, but only one-third of the 77 cases were studied preoperatively. Probably the most important single factor in the diagnosis of these tumors is the consideration of the possibility of their presence on the part of both the clinician and the radiologist when investigation of the other more common causative organs fails to reveal the cause of symptoms.

The basis of this report is a series of 10 cases of small bowel tumor personally treated or observed, demonstrating some of the outstanding clinical features and pathological types of these tumors. In view of the high operative mortality and poor survival rates, it seems justified to advocate an increased and recalled awareness as regards these tumors.

CASE REPORTS

CASE 1.—A white man, aged 50, was admitted to the hospital in August, 1941, the third time in 18 months, for severe melena. His gastrointestinal studies were inconclusive. On abdominal exploration, and only after almost complete examination of the small bowel, a 3 cm. solitary benign hemangioma was found on the mesenteric border of the distal ileum about 4 feet from the ileocecal junction. A resection was carried out. The patient is untraced, but recovery is presumed in this single, benign lesion.

CASE 2.—A white woman, aged 41, was seen in August, 1947, with a history of attacks of cramping abdominal pain. Roentgen-ray studies showed some small bowel dilatation interpreted as partial obstruction. At operation, a tumor proving to be carcinoid was found in the distal ileum. There were numerous enlarged nodes in the mesentery and nodules in the liver, one of which was subjected to biopsy and was carcinoid. A resection of 25 cm. of ileum and mesentery was done. This patient recovered from her operation and was last seen in good health in August, 1952.

Several reports indicate that secondary deposits of carcinoid may grow very slowly or remain quiescent, particularly when the primary growth is removed. Ogilvie[18] cited a case reported by Mallory in which the primary lesion was removed, but it was impossible to resect a retroperitoneal metastasis; 20 years later the patient died of pneumonia and a postmortem examination showed the mass unchanged except for some calcification. The rule should be that all tumor possible should be removed even if such procedure appears only palliative.[2, 18]

Dr. Mack F. Bowyer presented this paper to the Texas Surgical Society April 1, 1957, in Dallas and to former fellows of Alton Ochsner Medical Foundation October 16, 1957, in New Orleans.

Small bowel tumors are not rare though uncommon, and most are malignant or at least premalignant. This series of cases (all but 2 from private practice) demonstrate a variety of pathological types and major clinical manifestations. An increased awareness of the possible presence of such tumors is advocated.

CASE 3.—This case is included because the lesion was interpreted as actually arising from the duodenal mucosa. This was a 67 year old white man who was seen in May, 1954, with epigastric pain, jaundice, and itching of 2 weeks' duration. He had obstructive jaundice with a large palpable gallbladder.

At exploration a 2.0 cm. firm, slightly nodular tumor was felt in the ampullary region without evidence of metastatic involvement. A one stage pancreatico-duodenal resection was accomplished. Although a choledochojejunostomy was done, the gallbladder was left in for reasons which need not be discussed here. The gross specimen showed elevation of the mucosa in the ampullary region with separate openings of the dilated common and pancreatic ducts

(fig. 1). A cut section into the tumor showed invasion into the wall of the duodenum without gross evidence of involvement of the pancreas. A microscopic study was re-

Fig. 1. Case 3. Elevation of mucosa in the ampullary region and just distal.

ported as showing adenocarcinoma which appeared to spring from the mucosa of the duodenum heavily infiltrating the muscularis with no involvement of the pancreatic tissue (fig. 2).

In February, 1955, the patient was complaining of some cramping epigastric pain. A plain film showed a veritable "air cholangiogram" (or gas in the common and hepatic ducts); and after barium administration, not only the biliary tree but the pancreatic duct could be visualized. Perhaps, because of this reflux, this man developed "empyema" of the gallbladder in September, 1955 (symptoms were not too acute but the gallbladder became palpable). At operation for cholecystectomy, no evidence of tumor was found around the original site and no nodal involvement was detected, but a 3 cm. metastatic mass was discovered in each lobe of the liver. In subsequent months, the patient developed metastasis in the left supraclavicular nodes. Although no other masses or jaundice were ever apparent, he developed anorexia and marked cachexia and died September 25, 1956, 28 months after the initial resection. This compares to an average survival of 9 months after palliative, short circuiting operations only.

Originally, this appeared to be as favorable a case as we could expect to see. Little need be said about survival in these cases, which we know is bad, but resection should be done where there is any reasonable hope of success. Admittedly, most of these cases will not fit this latter criterion.

CASE 4.—A 55 year old white man was admitted to the hospital January 12, 1954, with tarry stools and weakness of 6 weeks' duration and showing 5 Gm. of hemoglobin per 100 cc. (32 per cent) on admission. He had had tarry stools in 1952 and was diagnosed as having and was treated for duodenal ulcer with relief. In 1933 he had been put on a diet with relief, after tarry stools of 1 month's duration.

After an upper gastrointestinal tract series of roentgen-ray studies made January 16, 1954, the third portion of the duodenum was reported as "lacking in normal mucosal markings indicating some possible infiltration at that site as sometimes seen in lymphosarcoma." This area looked normal in 1952 on review of films made then.

At exploration an unresectable mass was found involving the third and fourth portions of the duodenum. A biopsy of a subserosal nodule showed a highly anaplastic adenocarcinoma. An anterior gastroenterostomy was done. The patient continued to bleed at intervals, made no response to deep roentgen-ray therapy, developed obstruction at the gastroenterostomy stoma, and died 3 months after the original exploration. At autopsy, extensive generalized carcinomatosis was found throughout the abdomen and there was extensive ulceration and infiltration of the entire third portion of the duodenum. A postmortem microscopic section showed heavy invasion of the muscularis by highly anaplastic adenocarcinoma.

This case is an example of recurrent severe hemorrhage thought erroneously due to another more common cause, namely, a bleeding peptic ulcer.

CASE 5.—A white boy, aged 8 years (1950), had pain, distention, and vomiting for 12 hours. A large globular mass was palpable in the left upper quadrant of the abdomen. His preoperative hemoglobin was 6.3 Gm. (41 per cent). Significant in the history was that he had been sent to school several times in the previous 6 months with cramping abdominal pain.

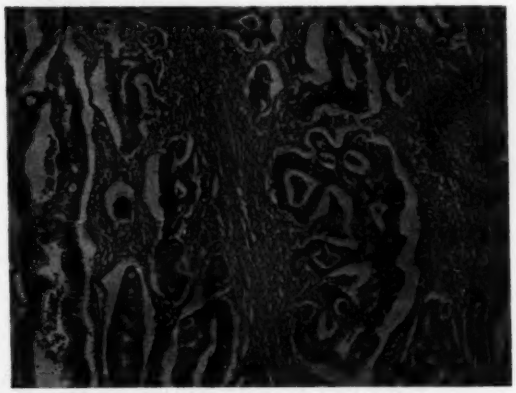

Fig. 2. Case 3. Adenocarcinoma originating in the duodenal mucosa and infiltrating the wall. A complete study showed no involvement of the head of the pancreas. x 220.

A supine film of the abdomen was somewhat confusing in that it showed no gaseous distention of the small bowel but a mass of increased density in the left upper quadrant due no doubt, in retrospect, to the fluid filled intussusception. At operation a strangulated intussusception was found, resulting from a 3 to 4 cm. polyp in the jejunum. A resection was carried out. Microscopic analysis was difficult as cellular detail

was hard to interpret because of hemorrhage, edema, and necrosis, but hyperplastic epithelial glands were found deep in the muscularis. This might be subject of some controversy, but a diagnosis was made of adenocarcinoma (papillary) developing in a jejunal polyp.

This boy is alive and well 7 years later.

This case is an example of (1) chronic hemorrhage, plus (2) recurrent intussusception and finally complete obstruction, and (3) at least premalignant change in a polyp of the small bowel.

CASE 6.—A boy was 7 years old when first operated on in 1951 for intussusception due to jejunal polyp. From 1951 through 1954, besides numerous bouts of abdominal cramping and anemia, he had 3 laparotomies with removal of 10 polyps from the jejunum and 1 large obstructing polyp from the pyloric region of the stomach. He has had few abdominal symptoms but mild secondary anemia since the last operation in 1954. General development has been good. He has shown heavy melanin pigmentation about the lips and mouth and smaller spots on face and hands.

An upper gastrointestinal tract series of roentgenograms made at one admission in October, 1953, showed a defect in the proximal jejunum interpreted as a polyp preoperatively. Microscopic sections of most of the removed polyps showed them to be true adenomatous polyps, and some showed real anaplasia in the glandular epithelium at the periphery.

Vary[32] quoted incidence of malignancy as 24 per cent in cases of multiple polyps showing anaplastic changes and expressed the belief that death from anemia and multiple intussusceptions, in the absence of a definitive attack on the disease, prevents many of these patients from reaching the age of maximum incidence of carcinoma. He also described a technique of multiple incisions into the bowel with extroversion of segments and destruction of multiple polyps by surgical removal and/or electrofulguration.

This case is an example of Peutz-Jeghers syndrome, which consists mainly of melanin pigmentation about the lips and buccal mucosa (and face and digits to a variable extent), associated with recurrent abdominal pain and anemia.[23] In the presence of these findings, the polyposis should be diagnosed clinically.[10] A plausible explanation of the melanin pigmentation would seem to be that stasis of intestinal contents due to constipation or chronic obstruction is believed to promote absorption of protein disintegration products which then are converted into pigment by a tyrosinase-like ferment. Melanophores (pigment carrying cells) are present in the subepithelial layers, and the amount of melanin in the skin is increased by exposure to sunlight, thus accounting for the pigmentation on the exposed parts.

CASE 7.—A white boy, aged 16, a brother of the patient in case 6, was admitted to the hospital July 25, 1954, with weakness and tarry stools noted for 1 week. Abdominal pain was not a prominent symptom. No distention was observed and no masses were palpable. His hemoglobin was 5.1 Gm. (33 per cent). The outstanding finding in this boy's work-up was an air contrast picture after barium enema showing a large polyp in the ascending colon (fig. 3).

Fig. 3. Case 7. Large polyp apparently in the ascending colon, but actually in the ileum. Intussusception was not suspected.

After supportive treatment and bowel preparation, laparotomy was performed. Surprisingly an ileocolic intussusception was encountered and easily reduced. Eight to 10 inches from the ileocecal valve, a large polyp was found in the terminal ileum (fig. 4). A 15 cm. segment of ileum was resected. In the upper jejunum another minimal intussusception was found, and on reduction, a polyp 1.5 cm. was discovered. The jejunum was opened and the polyp removed at its base. The opened specimen of ileum showed

Fig. 4. Case 7. The polyp shown in figure 3. A separate polyp was removed from the jejunum.

a 4 cm. sessile polyp with an area of necrosis near the base accounting for the bleeding. Both of these polyps were certainly adenomatous with very hyperplastic and irregular glands present even in the stalk. Lymph nodes studied were negative.

The patient made an uneventful recovery, was discharged 1 week postoperatively, and has remained well.

CASE 8.—A white man, a 69 year old rancher, was admitted to the hospital three times in 13 months with rather severe to massive upper gastrointestinal tract bleeding. Somewhat arbitrary and inconstant changes were noted in the cardia, pylorus, and duodenum on repeated radiographic studies of the gastrointestinal tract. He was treated supportively and put on an ulcer regimen at first admission (September, 1952). He remained symptom free between attacks. During his last admission (October, 1953) his studies again were inconclusive, and he continued to bleed in the hospital under treatment. On November 5, 1953, he was subjected to laparotomy.

A 4 cm. tumor was found in the midjejunum on the mesenteric border, showing extraluminal and intraluminal growth. Progressing proximally 30 cm. from the large tumor, a similar but smaller one was found. There was no evident nodal involvement or other metastasis. Two segments of bowel with tumor and mesentery were removed. Microscopically these tumors proved to be anaplastic tumors of mesodermal origin with areas resembling smooth muscle, and the diagnosis was sarcoma, probably leiomyosarcoma. The large tumor showed ulceration of the mucosal surface accounting for the bleeding.

This man is alive and well 3½ years post surgery.

This is an example of obscure severe hemorrhage (common in mesodermal tumors[23]) due in this case to sarcoma in the small bowel.

CASE 9.—A white woman, aged 73, was seen September 13, 1953. She had had 5 major operations since 1941, including 2 for obstruction. History of symptoms was of 9 weeks' duration with sudden onset of cramping abdominal pain with distention and vomiting, alternating with spells of diarrhea. With onset of the present illness a generalized urticaria and eczema developed and had been treated with several weeks of cortisone therapy. She had received 4 electroshock treatments and "mild doses" of insulin for "psychosomatic involutional depression." A colon roentgen-ray study had been inconclusive previously, but on this last admission, a supine film was interpreted as showing fairly high grade partial small bowel obstruction probably due to adhesions.

At laparotomy, adhesions were numerous, but the real cause of obstruction was a napkin ring type of infiltrative lesion 4 cm. from the ileocecal junction with 3 grayish flat plaques on the adjacent mesentery which showed adenocarcinoma on frozen section. An aseptic resection and ileocolic anastomosis was accomplished. Microscopic analysis confirmed that this was a highly anaplastic adenocarcinoma invading the entire wall in areas. This was a 4 hour operation, but the patient's condition was considered satisfactory (with systolic blood pressure of 100) at the end of surgery. Shortly after returning to her room she had a vascular collapse, failed to respond to any supportive measures, and died 6 hours postoperatively.

An autopsy showed no intraperitoneal bleeding and no evidence of metastatic disease. The lungs showed some basilar pneumonia. Although a recent microscopic study of the adrenal glands was inconclusive, the cause of death is now presumed to have been adrenal failure and vascular collapse from previous cortisone therapy.

CASE 10.—A white woman, aged 61, was observed in consultation in February, 1955. Chief complaints were attacks of nausea, vomiting, gas formation with distention, and cramping upper abdominal pain at intervals for 25 years but with increasing frequency and severity in the previous few months. Confusing points of information are too numerous to discuss, but chief among these were a known gallstone since 1949 and attacks of jaundice in 1950 and 1953. On the 5 hour film after an upper gastrointestinal tract series, marked loss of mucosal markings were reported with areas of dilatation and segmentation of the barium. The amount of dilatation was considered compatible only with some chronic mechanical obstruction.

At exploratory surgery, a very narrow, small, fibrous, constricting tumor was found in the ileum, and a limited resection was done after a mesenteric node was considered negative on frozen section. Study of permanent sections revealed this to be a carcinoid. One of 2 mesenteric nodes showed metastatic growth. Because of finding of the positive node, the patient was readmitted for a wider resection 5 weeks after the first operation. At operation a tumor mass 6 cm. in diameter was found in the mesentery of the ileum 12 inches from the ileocecal valve without other gross evidence of node or liver involvement. The mass and 14 inches of terminal ileum were removed en bloc. The mass was carcinoid tumor; several nodes in the specimen contained no carcinoid. She has remained well and symptom free on a low fat diet for 2 years post surgery.

Further study of the original tumor revealed it to be rather typical carcinoid, composed of masses and sheets of small cells separated by dense stroma (maybe the reason for slow growth), but in selected areas there were masses of larger cells showing many mitoses and other evidences of anaplasia, these masses being divided by scanty stroma. These criteria make the diagnosis of malignant carcinoid, microscopically (fig. 5).

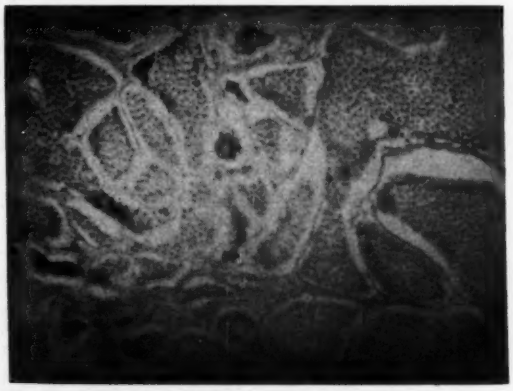

Fig. 5. Case 10. Malignant carcinoid. Although the picture is not good for cellular study, the general configuration of large masses of large cells with scanty stroma can be seen readily. x 220.

A malignant carcinoid syndrome has been described in which there are extensive liver metastases. This syndrome is considered to be due to an excess in the serum of a substance called seratonin (5-hydroxytryptamine), which is produced by enterchromaffin cells and usually broken down in the liver (to 5-hydroxyindolacetic acid). Both the substance in the serum and its breakdown product in the urine can be assayed biologically. The syndrome is manifested by abdominal pain due to hypermotility of the intestinal tract, often diarrhea, bouts of flushing of the skin, hypotension, total or partial cyanosis (in the absence of polycythemia), characteristic changes in the right side of the heart (usually pulmonary stenosis and

tricuspid insufficiency), and sometimes an unusual type of bronchial asthma due to bronchoconstriction.

Carcinoids have been reported from the stomach to the rectum. Seventeen of Weibel's 100 cases of malignant small bowel tumors were carcinoids, and in 47 per cent of these metastases were demonstrated. The tumors were multiple in 3 cases. Most grow very slowly and do not encircle the bowel completely in the early stages. Ulceration is the exception rather than the rule.[18] As pointed out previously, progression of secondary deposits may be extremely slow. Wide resection, even though it appears palliative, should be reemphasized.

SUMMARY AND CONCLUSIONS

Small bowel tumors are not rare but rather uncommonly encountered.

A majority of these tumors are malignant, and in the 10 cases presented, all but 1 either are malignant or must be considered premalignant. These cases show a variety of pathological types and major clinical manifestations. They were classified as 6 malignant (3 adenocarcinoma, 1 sarcoma, and 2 carcinoid); 3 premalignant (adenomatous polyps); and 1 benign hemangioma.

Operative mortality rates have been high in the past and survival rates poor because of several factors, but surgeons, internists, and radiologists alike need to be more "small bowel conscious," particularly in cases of unexplained recurrent abdominal discomfort associated with anemia. Such cases associated also with melanin pigmentation about the lips, face, and digits should be diagnosed clinically (Peutz-Jeghers syndrome).

Carcinoid tumors in the small bowel are considered to be malignant, but the outlook is good where the primary growth is removed and may be good even in the face of unresectable metastases. Malignant carcinoid syndrome is mentioned and briefly discussed.

This is a plea for an increased awareness of the possibility of small bowel tumors.

ADDENDUM

Since presentation of this paper, 2 more cases of small bowel tumor have been treated or observed. One showed aberrant pancreatic tissue on the antimesenteric border of the jejunum found incidentally in a case of obstruction lower down due to a bezoar. The second was a strangulated irreducible intussusception (ileo-ileal) due to an adenomatous polyp in an infant girl 5 months old. Both patients recovered.

The very recent literature contains several articles on small bowel tumor,[2, 3, 4, 6, 7] but malignant carcinoid syndrome is brought into particular focus.[1, 5] This condition is variously referred to as a new metabolic disorder or as due to an endocrine tumor the secretion of which gives rise to the characteristic clinical manifestations through its action on smooth muscle. A simplified chemical test for the breakdown product (5-hydroxyindoleacetic acid) has been worked out.[5]

I would express appreciation to the following local colleagues for inclusion of their cases; Dr. O. E. Harper (case 10), Dr. E. E. Middleton (case 8), Dr. G. D. Thurman (cases 5 and 6), and Dr. H. H. Hamilton (aberrant pancreas mentioned in addendum). Dr. J. E. Williams, pathologist, and Charles Cockerell, photographer, are to be thanked for their efforts in the preparation of slides. The Texas Medical Association Memorial Library was cooperative and helpful in sending literature and completing the bibliography. My secretary, Miss Wanda Trice, is to be remembered for repeated preparation of the manuscript.

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A bibliography is available from the author.

Dr. Bowyer, 1101 North Nineteenth, Abilene.

Rehabilitation Problems Of the Physically Handicapped Child In Texas

ODON F. VON WERSSOWETZ, M.D., F.A.C.P.

Gonzales, Texas

THE MODERN concept of comprehensive rehabilitation of the physically handicapped child aims to overcome as far as possible the causative factors and the associated residual complications which have been acquired through the chronic effects of disease or injury. This program should assist the child to live as normal a life as possible in spite of his handicap. It must be offered not only to those children who obviously will improve satisfactorily and achieve a high degree of recovery, but also to those for whom the prognosis up to the present time has been regarded as totally hopeless.

Rehabilitation should not be denied to a child with a fatal prognosis because of the progressive nature of the disease and because the child is not expected to live more than 5 or 10 years. Such severely involved

children should have the same opportunity to maintain to the utmost those few assets and capabilities that they have remaining to them with the hope that they may reap the results of future scientific discoveries and be prepared to accept these, both physically and mentally. The list of curable diseases is rapidly expanding; therefore, it is of the greatest importance to retain the remaining skills and to prevent deformities in these severely handicapped children.

Dr. Odon F. von Werssowetz, Medical Director of the Gonzales Warm Springs Rehabilitation Foundation, presented this presidential address to the Texas Physical Medicine and Rehabilitation Society, April 20, 1958, in Houston.

Rehabilitation for the handicapped child should include hospital in-patient, out-patient, and home care. A team of at least three physicians should evaluate the child for treatment; follow-up should be conducted regularly. The child should be helped to live as normally as possible. State laws and rehabilitative funds need attention.

The philosophical attitude of the total comprehensive rehabilitation program should be that we are raising a child with some disability and not treating a certain disease and its victim. It must be remembered that physical disabilities in general do not affect the child's mental aptitudes unless there is direct impairment of the brain. Such a child should have not only physical treatment but also as many normal mental outlets as possible because such a child has normal desires, urges, dreams, and emotions. It is imperative that every effort be made to help this child to experience the variable facets of everyday living and to participate in all the activities he is able to do, with the hope of developing in such a child self-reliance in his own personal management.

How can such a program of total care be carried out? The total rehabilitation program can be divided into three areas of effort, that is, (1) hospital in-patient care, (2) out-patient clinic care, and (3) home care.

HOSPITAL IN-PATIENT CARE

Hospital in-patient care, though not the most desirable method of treatment of children, is required in most cases to determine the type and extent of the disability. It is necessary when reconstructive surgery is contemplated to correct certain deformities. Its greatest value, however, is in rehabilitation procedures because it is essential to establish or re-establish normal patterns of motion and activity which are not retained well by these young patients. If faulty patterns are allowed to persist or are only corrected halfheartedly, severe complications and deformities may ensue. It is evident that this type of care will be required sporadically by most handicapped children until their conditions become well stabilized, usually around puberty.

The hospital program for such patients not only must encompass the rehabilitation of the physical deficiencies and associated impairments imposed by the residuals of any neuromuscular disability or musculoskeletal disorder, but also must consider the emotional and educational necessities of each child. The program, influenced by vast causative factors of impairment and disability, must be so planned as to provide a scientifically balanced and highly progressive therapy for each type of medical and surgical condition and for each successive grade in the process of recovery. The actual treatment program for each child must be individually prescribed after a thorough evaluation. It is obvious that only after such an evaluation can treatment be applied efficiently and effectively with logical regard for function and personality. The aim of this treatment is the prevention of permanent deformities or disabilities and the development of the remaining potentialities to the fullest functional capabilities.

The evaluation and treatment of such children requires the integrated efforts of numerous disciplines which are well coordinated by close cooperation of a team of professional personnel. This is a necessity in today's modern scientific medicine, because no one individual, no matter how gifted he may be, is able to know all the diverse evaluation and treatment techniques. Teamwork is not solely found in rehabilitation—it is used extensively in surgery and other areas of medicine.

The determination of the extent of disability cannot be made in a cursory manner during a 5 or 10 minute interview. Because of the emotional trauma imposed on the child from an interview by total strangers, such an evaluation is inadequate if not entirely useless. It is found that an adequate evaluation can be made only after 3 or 4 weeks of observation of the child on an in-patient basis in an appropriate center. The evaluation should be conducted by a team composed of at least a physiatrist, a pediatrician, and an orthopedic surgeon. This team should avail itself of the services of other medical specialists and professional personnel for specific examinations as needed. Only after such an evaluation under observation can the true potential of the child be determined. A child rejected for treatment by such a team should be reexamined regularly at yearly or other specified periods to determine if changes occurring with maturation do not render him capable of responding to rehabilitation procedures.

Unfortunately in Texas the antiquated laws and regulations do not provide facilities for observation or for the modern scientific medical evaluation by a team of physicians. As long as these conditions exist the care of the majority of handicapped children will be inadequate and unsatisfactory. Another deficiency existing in our state in regard to the care of the handicapped child is the lack of understanding of the value of intensive treatment at a comprehensive rehabilitation center. This is on the part of not only the lay public, but also the physician and professional worker as well as agencies sponsoring such care. This requires educational effort to acquaint the public in general, and the medical profession in particular, of the value and available sources for such treatment.

It is obvious that a child who ambulates with braces and crutches, though trained satisfactorily in their use, gradually will develop abnormal patterns which can be corrected only by an intense training program. Other conditions, like tightnesses and contractures, tend to recur in spite of home care. These patients will require sporadic intensive treatment in a rehabilitation center. It is also apparent that intensive rehabilitation after the majority of surgical procedures for correction of deformities enhances the functional results in handicapped children. It is obvious that most handicapped children will require continued care after they leave the rehabilitation center. This is given in out-patient clinics or at home.

OUT-PATIENT CLINIC CARE

Out-patient care is administered in the child's own community by qualified therapists, under the supervision of the family physician or an appropriate consultant. The primary aim of such a program should be essentially to maintain the corrections obtained during intensive rehabilitation treatment. It also should provide an evaluation of the child's progress. Out-patient care is a valuable means of rendering treatment to handicapped children; however, its limitations should be well recognized. It is not, and cannot provide, a comprehensive program because of the limited number of diversified professional personnel available to such a clinic. Such a clinic is usually staffed with one or two physical therapists. It is obvious that a physical therapist can provide only physical treatment and cannot be expected to administer speech therapy.

The other factor is that such a program cannot be intensive enough to obtain satisfactory results. In Texas, expert out-patient care is available only in a few communities because there are not enough well qualified and trained therapists in rehabilitation procedures. This program should not be left to the haphazard device of any physical therapist who happens to have been practicing massage and electrotherapy over a course of years. Rehabilitation is a scientific form of treatment requiring excellent knowledge of the essential basic procedures.

There is a great need in Texas for expanding these out-patient treatment clinics although it is first necessary to obtain well qualified personnel. It would seem expedient to have these therapists trained in the available centers so that the continuity of the treatment is maintained. These therapists should be free to provide the prescribed therapeutic procedures and should not be burdened with administrative or other duties. They should have close medical supervision, and their work should be evaluated at regular intervals.

HOME CARE

In numerous cases, the parents of the handicapped child are given a routine of procedures to be carried out at home. The parents, though thoroughly instructed in a few home procedures, are not trained to observe the noxious changes in their child, which, gradually creeping in, may lead to the assumption of faulty patterns and irreversible deformities. This is an area in which there is a definite need for a major improvement by providing some supervision and help to the parents.

I believe that the public health nurse, given 4 weeks of adequate intensive indoctrination and training in rehabilitation procedures in one of the four centers existing in Texas, could well supervise home routines, such as positioning, mobilization, simple exercises, and gait training. At least a public health nurse should be able to note if there is any regression in the child's condition and request necessary reexamination. There is another factor of importance in such a program. It is too often found that the parents, for one cause or another, neglect to follow the home routine. In consequence the child develops deformities, which may require prolonged hospitalization with its additional cost. Here exists some disagreement as to how to proceed in such cases. There are those who feel that the treatment should be terminated and the parents left to their own devices. However, I believe that some legal means should be made available to make it mandatory for such a child to receive adequate treatment. This eventually will result not only in lessening the disability for the child, but also in economic profit for society.

The visiting public health nurse would be in a position to recognize the home conditions quite readily and could take the necessary steps to alleviate them. The nurse should be supplied with the necessary treatment information from the various centers. She could check the home program, thus materially improving the total care of the child. She also could

help the parents to understand, accept, and adjust to their child's limitations imposed by his handicap. She could indicate to the parents the potentials and capabilities of the child. She would maintain a liaison between the family and the medical profession, in addition to serving as a link with the community and especially the schools.

The education of a physically handicapped child is a complex problem and can be accomplished adequately only through an understanding of the elements in a well rounded program leading to physical, intellectual, social, and emotional growth. Those who participate in such a program must have knowledges and attitudes which will foster the development of the child in all of these areas. It is my belief that the physically handicapped child should attend a normal, average school—and only under few exceptional conditions should he attend a special school or class for the so-called exceptional children. A physically handicapped child usually is normal mentally and often has above the average intelligence. He needs normal stimulation and environment to develop normally. He has to live in the average, normal environment and adjust to its behavior. It is much easier to do this among his own friends when young than to do it later among strangers.

Another important factor which we tend to neglect in our rehabilitation programs is that we concentrate on the handicapped individuals and neglect the normal ones. These average normal individuals also have to become adjusted to disabled people, and this can be best done in their childhood. If the handicapped grow up with normal children, they are readily accepted and their accomplishments are known. Therefore, it will be much easier for them to gain employment, economic independence, and social position.

The placement of such children in normal schools, meets with great difficulties. Some of our educational leaders are not too cooperative. Our schools may not be easily adapted structurally—often there is the question of transportation. Where there is a will, however, means are always found to overcome such difficulties. An example of such a case was a severely involved child of about 13 years of age who needed to attend school in Galveston, where most of the homes are elevated. Arrangements were made by which each morning two policemen picked the girl up, carried her down the stairs, and drove her to school. In the afternoon the procedure was reversed. This is commendable, but this cooperation is found in too few communities.

The leaders of our schools and the communities themselves must be made aware of the great need of schooling for the ever growing number of handicapped children. Unless the handicapped child is accepted without reservation and the facilities of our school system are extended to provide for the carryover of the total rehabilitation program to the school room, our efforts will meet with failure and will be in vain.

It is obvious that securing satisfactory care for the handicapped child requires adequate funds. This always appears to be a great problem because there seems to be a general public apathy when this question is discussed. But the treatment of many severely handicapped children, which extends over a period of months and years, is costly. These children cannot wait for years. They need these services now.

The problem is in the amount of state money available for such services. For the year 1954, the Children's Bureau reported that 63.2 per cent of the funds spent by the Division of Crippled Children's Services in Texas was derived from federal grants, while the average for the United States was 26½ per cent. During this report period the state appropriated 10 cents and the federal government 17 cents to make the total of 27 cents spent per child in Texas. This amount was next to the lowest for all the states. The average in the United States was 75 cents per child under 21 years of age, of which 55 cents was derived from state or local funds. How, under these circumstances, can the program for crippled children in Texas meet even the minimal demands?

The services which handicapped children require are expanding. This, as well as the growing labor cost, demands a budget which would be sufficient adequately to meet these needs. Because of inadequate funds, there are children who are denied treatment when it would do the most good. This cannot be tolerated.

CONCLUSIONS

The problem of rehabilitating the handicapped child deserves direct attack:

1. There should be adequate utilization of available services and expansion as needed. There is a need to educate the physicians, paramedical professional personnel, and the public as to the types and limitations of rehabilitation services available in the state.

2. Diagnostic and treatment services should be available to every child without restriction.

3. Diagnostic evaluation should be made by a team of at least three physicians representing the specialties of pediatrics, physical medicine, and orthopedic surgery, assisted as needed by other physicians and ancillary personnel.

4. Periodic reevaluation conducted at regular intervals is necessary not only because of inadequacies of testing, but also because of changes occurring in the child's physical and emotional growth from maturation or from regression caused by his illness.

5. Provisions should be made for adequate follow-up in home communities by public health nurses or social service workers.

6. Provisions for better liaison for normal schooling of the physically handicapped child should be made if his condition permits.

7. Inadequate state laws should be modernized.

8. Adequate state funds should be secured to cover the needs for emergency as well as of chronic conditions so that all handicapped children receive the necessary treatment and care when it is needed and do not have to wait until funds become available.

These are but a few recommendations that need to be considered without delay. The handicapped child does not wait, but it grows. Tomorrow may be too late for some child who may develop a permanent deformity resulting in a severe disability which may handicap him for life. This we cannot allow to happen.

♦ Dr. von Werssowetz, Gonzales Warm Springs Rehabilitation Foundation, Gonzales.

Moniliasis

Treatment with Nystatin Powder

JAMES H. STRAUCH, M.D., and ROBERT LEVINE, Major (MC) USAF

San Antonio, Texas

INFECTION of intertriginous areas with Candida albicans has been notoriously resistant to therapy. Many fungicides effective in vitro have failed in our experience to eliminate the infection consistently in actual use on the skin. These preparations have included 0.5 to 2 per cent gentian violet, Castellani's paint, 1 to 3 per cent salicylic acid solutions, 3 to 5 per cent resorcinol solutions, 0.1 to 0.25 per cent silver nitrate solutions, ammoniated mercury ointment, benzothiazole ointment, Vioform cream and ointment, Vioform in talc, and fatty acid ointments and powders. These medications have all been helpful at times, but consistent, rapid cure of the infection is unusual.

Recently, an antifungal antibiotic known as nystatin, derived from cultures of Streptomyces noursei, has been shown to have marked fungistatic action against Candida albicans in vitro.[1] In addition nystatin ointment has been found to be effective in moniliasis of the skin.[2, 4] However, the ointment preparation, although stable, is messy and uncomfortable in use in a hot, humid climate. Also, in intertriginous areas ointments are tolerated poorly, and occasionally cause folliculitis or furuncles to appear. Osbourn[3] recommended a watery lotion containing nystatin. Nystatin was supplied by grinding up oral tablets of nystatin after removal of the gelatin coating. This lotion was very effective in intertriginous moniliasis, according to Higdon.[2] However, we believed this preparation had the following disadvantages:

1. The watery suspension is unstable and loses potency rapidly. For example, nystatin loses 37.5 per cent of potency in water suspension in 6 hours at room temperature.[1]

2. Nystatin is almost completely insoluble in water (300 to 600 units per milliliter).[1]

3. Since moisture aggravates the infection and the areas usually are already moist with perspiration in intertriginous areas, a watery lotion is probably contraindicated.

4. Removal of the gelatin coating is clumsy for the pharmacist, and the resulting suspension is often gritty.

It was therefore decided to treat intertriginous moniliasis with pure nystatin powder suspended in talc. Such a preparation should help in drying the areas to be treated, would be stable, and would be colorless, nonstaining, and simpler to use. Full strength nystatin powder patch tests on 5 normal controls showed no irritation.

MATERIALS

A 3 per cent suspension of nystatin powder in talc was obtained.* Also, pure nystatin powder (3,500 units per milligram) was supplied* in order to increase the concentration of nystatin if necessary. The patients were directed to dust the nystatin in talc on the lesions four times a day.

The diagnosis of infection with Candida albicans was made on the basis of microscopic examination for fungal elements on a skin scraping in a suspected area and on the clinical appearance of bright red moist erythema and macerated skin with satellite shallow vesicles and vesicopustules in intertriginous areas, such as the axillae, submammary creases, inguinal and crural areas, scrotum, and gluteal cleft. Cultures were made on corn meal agar for confirmation of some unusual cases. The climatic conditions under which the patients lived varied, according to the amount of exposure to air-conditioning, but most patients were treated during the hot summer months in a semitropical climate. A summary of case histories follows.

**Nystatin in talc and nystatin powder were supplied by Dr. Gavin Hildick-Smith, associate medical director, The Squibb Institute for Medical Research, New Brunswick, N. J.*

CASE HISTORIES

CASE 1.—A woman, aged 25, who was 6 months pregnant, complained of eruption in both axillae of 1 week's duration. Typical erythema and erosions were present in both axillae; the eruptions were positive on potassium hydroxide examination for fungal elements. In 1 week of treatment with nystatin powder in talc the axillae were completely clear.

CASE 2.—A 21 year old male pharmacist complained of tender, pruritic crural eruption for 3 weeks. Examination showed erythema, scaling, and maceration of crural areas and the lateral aspects of scrotum and penis, with shallow satellite vesicopustular lesions. A potassium hydroxide preparation tested positive for fungal elements. The involved areas were completely clear after 2 weeks' therapy with nystatin powder in talc.

Dr. James H. Strauch is civilian consultant in dermatology at Lackland Air Force Base Hospital.

Infection of intertriginous areas with Candida albicans has been resistant to therapy. Nystatin powder in talc was promptly and consistently effective in such cases even with underlying aggravating factors. No irritation or sensitization occurred in 21 cases studied, and the medication met with excellent patient acceptance.

CASE 3.—A 25 year old woman, pregnant 6 months, while being treated with Terramycin for impetigo developed an axillary eruption. Axillae presented typical lesions, positive for fungal elements on potassium hydroxide examination. There was complete clearing in 2 weeks on nystatin powder in talc.

CASE 4.—A 22 year old man while on his honeymoon developed bulbar poliomyelitis, requiring treatment in a respirator. He had high fever, modified Kenney treatment with hot compresses, and a non-air-conditioned room in which the temperature varied from 80 to 100 F. daily. He had treatment with various antibiotics. Monilial infection of the crural areas and gluteal cleft developed at 1 week and failed to respond to salicylic acid–resorcinol lotion and Desenex powder. His back was almost constantly moist and became covered with shallow vesicles. The back lesions were positive for Candida albicans on culture and potassium hydroxide examination of scrapings. All areas cleared completely in 1 week on 5 per cent nystatin powder in talc. Relief of intolerable pruritus (scratching was impossible because of paralysis of arms) was obtained in 24 hours.

CASE 5.—A man, aged 25, complained of recurring foot eruption of 18 months' duration, requiring repeated hospitalization. Previous therapy included gentian violet, potassium permanganate soaks, Desenex ointment and powder, Burow's solution soaks, roentgen-ray therapy, Vioform ointment, and Whitfield's ointment. On examination the feet presented massive hyperkeratosis between and beneath all toes, with marked maceration. Three cultures were positive for Candida albicans, and potassium hydroxide smears showed fungal elements. Biopsy showed numerous fungal elements in the epidermis. Nystatin powder in talc produced marked clearing in 2 weeks. Relapse occurred on stopping medication, and clearing occurred on resuming medication. After 2 months slight scaling between the toes was still present. Since no other fungi were cultured, this was diagnosed as monilial infection of the feet.

CASE 6.—In a male infant, aged 6 months, a spreading eruption in the diaper area was noted for 2 weeks. On examination the penis, scrotum, pubis, crural areas, and buttocks showed moist scaling areas with maceration and satellite vesicopustules. A potassium hydroxide smear was positive for fungal elements. Nystatin powder in talc produced complete clearing in 2 weeks.

CASE 7.—An 8 month old girl had spreading eruption on the buttocks for 6 months. No improvement was observed after treatment with Florinef ointment, sulfur–salicylic acid ointment, or Desenex ointment. The eruption cleared on use of nystatin ointment. The same areas had a recurrence of dermatitis 1 month later. Permanent clearing occurred after 1 week on nystatin powder in talc.

CASE 8.—A woman, aged 50, had recurring vulvar pruritus for 2 years, following excision of a vulvar cyst, bladder infection, and antibiotic therapy. Clearing occurred with Vioform ointment. One year later she had a recurrence of vulvar pruritus after taking a sulfonamide for bladder infection. On examination the vulva was bright red, with whitish exudate. A potassium hydroxide smear revealed Monilia organisms. Clearing occurred in 4 weeks of treatment with nystatin suppositories in the vagina and nystatin powder in talc externally. No recurrence had been noted 18 months later.

CASE 9.—A 50 year old lawyer had chronic scrotal and perineal neurodermatitis. He recently had vesicular lesions on the scrotum and on crural areas. Examination revealed shallow vesicles and guttate desquamating areas on the crural folds and scrotum. Potassium hydroxide smears were positive for fungal elements. The vesicular lesions disappeared in 1 week of treatment with nystatin powder in talc. Residual lichenified neurodermatitis of the scrotal and perineal areas was unchanged.

CASE 10.—A woman, aged 40, complained of crural and vulvar stinging and burning for 3 weeks. No precipitating factor other than hot weather was identified. On examination the vulva and crural areas presented diffuse erythema and satellite shallow vesicles and desquamating guttate lesions. A potassium hydroxide test revealed Monilia organisms. In 1 week clearing occurred with nystatin ointment. Recurrence developed over 3 weeks. Slow clearing occurred on 0.5 per cent gentian violet and 5 per cent nystatin powder in a watery lotion. Two weeks later lesions disappeared in 2 days on nystatin powder in talc. No recurrence was noted after a year.

CASE 11.—A 45 year old man had crural dermatitis for 1 month. He also had severe seborrheic dermatitis of chest and scalp. There was gradual clearing in 1 month with therapy using 5 per cent nystatin powder in watery lotion. The dermatitis cleared after 2 weeks of nystatin powder in talc. Mild relapses occurred for 3 months; the condition was controlled with nystatin powder in talc.

CASE 12.—A 50 year old male pharmaceutical representative had crural eruption for 1 month. Dyclone and antibiotic ointment were used locally without relief. On examination the patient was noted to be moderately obese. The entire inguinal, crural, perineal, perianal, and gluteal cleft areas presented bright red erythema, maceration, scaling, and satellite scaly guttate lesions. Potassium hydroxide tests were positive for fungal elements. Nystatin powder in

talc relieved symptoms in 2 days, with complete clearing of skin eruption in 9 days. Intermittent applications were necessary for mild recurrences for 2 months; then complete clearing occurred.

CASE 13.—A woman, aged 50, with mild diabetes, had had lesions beneath the breasts and in the umbilical area for several months, with marked pruritus. Examination revealed typical clinical findings, and a potassium hydroxide smear was positive. Treatment with nystatin powder in talc resulted in relief of symptoms in 2 days, complete clearing in 10 days, with no recurrence in 18 months.

CASE 14.—A 52 year old man had had recurrent crural eruption in the summer for years. The present eruption had lasted 1 month. The patient had gained 75 pounds in the past 3 years. Examination revealed erythema, scaling, and satellite vesicopustular lesions in the crural areas. The eruption cleared in 1 week on nystatin powder in talc. No recurrence was observed in 1 year.

CASE 15.—A 45 year old female manufacturing executive had had recurrent vulvar pruritus for 5 years, worse in the summer, with recent eruption on the arms. Examination revealed papules of lichen planus on the arms. The vulva presented bright red erythema and cheesy exudate, extending out to the crural areas. A potassium hydroxide smear was positive for fungal elements. Nystatin powder in talc resulted in marked clearing in crural-vulvar lesions in 1 week. Mild recurrences occurred during a 1 year period but responded to the same medication.

CASE 16.—A 55 year old male hotel manager complained of eruption in the groin and gluteal cleft for 1 month. Following transurethral prostatectomy 3 months before, he had had some urinary incontinence and wore a pad and suspensory. After urethral examinations he took Chloromycetin to prevent infection. Examination revealed erythema, scaling, and maceration of scrotum, crural areas, and gluteal cleft. A potassium hydroxide smear was positive for fungal elements; a culture was positive for Candida albicans. The condition was cleared in 1 week of nystatin powder in talc. A relapse 1 month later cleared on 5 per cent nystatin powder in talc. There was no recurrence after 1 year.

CASE 17.—A boy, aged 13, had a crural eruption for 1 month. He had had similar trouble the summer before. Examination revealed typical erythema and scaling on the scrotum, penis, and crural areas. A potassium hydroxide smear was positive for fungal elements. After 1 week of therapy with 3 per cent amphotericin powder lesions were still red and slightly raised. Complete clearing occurred in 1 week on nystatin powder in talc, with no recurrence on reexamination in 6 months.

CASE 18.—A 7 month old girl had lesions on the diaper area for 6 weeks, with no response to hydrocortisone ointment or Desitin ointment. On examination, crural areas presented maceration and erythema with cheesy exudate. The condition cleared in 1 week on nystatin ointment therapy. Lesions recurred 2 months later, but cleared after 10 days of treatment with nystatin powder in talc. No recurrence was noted in 18 months.

CASE 19.—A girl, aged 5 weeks, had eruption in the diaper area for 1 month. She had had thrush after birth. There was no response to ZBT powder, silver nitrate, zinc oxide ointment, and Spectrocin ointment. On examination, pubic and crural areas presented erythema and shallow erosions. A potassium hydroxide smear was positive for fungal elements. The eruption cleared in 1 week of treatment with nystatin powder in talc, and there was no recurrence in 1 year.

CASE 20.—A 49 year old male physician had an eruption on crural areas and gluteal cleft for 1 month. There were typical clinical findings. The condition cleared in 1 week of therapy with nystatin powder in talc; there was no recurrence in 1 year of observation.

CASE 21.—A man, aged 45, had had brownish velvety areas in the axillae of 2 years' duration, with recent redness and pruritus of the axillae. Examination revealed velvety, brown, slightly papillomatous areas in both axillae, with central bright red erythema, and satellite vesicopustules on the border of the lesions. A potassium hydroxide smear was positive for fungal elements. The diagnosis was benign acanthosis nigricans and moniliasis. The lesions typical of moniliasis cleared in 1 week on nystatin powder in talc; the underlying benign acanthosis nigricans was unchanged.

DISCUSSION

The effect of nystatin powder in talc on intertriginous monilial infections was remarkably consistent in all the cases treated. Cure was eventually achieved in 20 of the 21 cases. The remaining case of an unusual monilia infection between the toes was markedly improved, even though not completely cured. In some cases improvement was really spectacular, with complete relief of symptoms in 2 days and complete clearing in 1 week to 10 days. No irritation or sensitization was seen in any case. The medication was well accepted by all patients, even though underlying skin disease such as neurodermatitis was present. In no case was any time lost from work for the purpose of medicating the skin, such as is often necessary with use of ointments or dyes.

Those patients who previously had used wet dressings, ointments, dyes, or nystatin powder in watery lotion invariably preferred the powder type of medication. The specificity of therapeutic action seemed to be enough to conquer the underlying precipitating causes of the monilial infection such as excessive sweating, nonporous clothing such as starched heavy cotton twill, diabetes, obesity, contamination of areas with urine, previous antibiotic therapy, high fever, and pregnancy. Relapses seemed to be easily controlled with the same medication, although in a few cases it was necessary to raise the concentration of nystatin from 3 to 5 per cent.

The final impression was that 3 per cent nystatin powder in talc was the most speedily and consistently effective medication we had ever used in treating intertriginous Monilia infections, and also was the best tolerated by the patients.

SUMMARY

Nystatin, 3 per cent in talc, was promptly and consistently effective in treatment of cases of proven Monilia infection in various intertriginous areas.

No irritation or sensitization to the medication occurred in the series of 21 cases studied.

Fig. 1

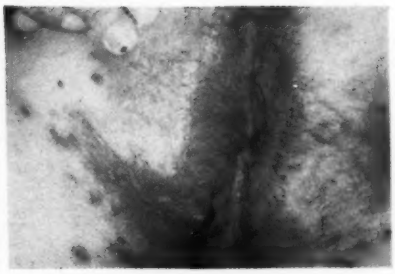

Fig. 2

Fig. 3

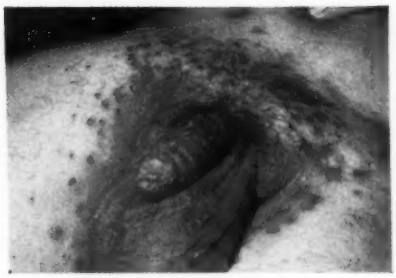

Fig. 4

Fig. 1. Case 5. Moniliasis of feet.
Fig. 2. Case 12. Moniliasis of perianal area and gluteal crease.
Fig. 3. Clinical appearance in severe moniliasis of axilla.

Fig. 4. Typical appearance in genito-crural moniliasis. Note particularly involvement of the penis and scrotum, and "satellite" lesions.

The color plates were made possilbe by a grant from the Squibb Institute for Medical Research, New Brunswick, N. J.

The medication was well tolerated and clean, with excellent patient acceptance.

Clearing of Monilia infection occurred promptly in spite of aggravating factors such as diabetes, obesity, contamination of skin with urine, excessive perspiration, and nonporous clothing.

Three per cent nystatin in talc was more effective than other standard treatments previously used in our practice.

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♦ Dr. Strauch, 610 Medical Professional Building, San Antonio 12.

Dr. Levine, Lackland Air Force Base Hospital, San Antonio.

Preserving Freedom of Choice

HOWARD A. MOREEN

Hartford, Connecticut

I NEED not remind physicians of the continuous threat we must combat to prevent socialization of medicine. This threat will always be with us. Witness the programs in most countries in Europe and witness the recent development in Canada where a national hospitalization program is about to be launched. Three of the 10 provinces in Canada already have a governmental hospital plan. Two other provinces have partial plans which probably will be extended. Ontario has announced a hospital plan to go into effect January 1, 1959.

Thus, Canada soon will have most hospital care under government financing, and along with financing will go control. Will this trend toward governmental financing spread to our country?

Will medicine eventually be encompassed in the Canadian program? Whereas the doctors in Canada do not seem to be alarmed about the hospital program, the question as to whether medicine will be encompassed should probably be rephrased — How soon will medicine be included?

It is easy for us to say that it cannot happen here. Still there are those in influential places who advocate that a nationalized health insurance program is necessary in order to place good medicine within the financial reach of everyone.

How do we in the insurance industry fit into the picture of preserving free enterprise in medicine and, incidentally, also preserving free enterprise in health insurance? I am convinced that the best possible medicine can be provided only if the physicians are free of governmental control. American doctors have demonstrated this. In our country we have the highest standards and finest medical care available.

Howard A. Moreen, past chairman of the Health Insurance Council and vice-president of Aetna Life Insurance Company, delivered this address April 21, 1958, at the General Meeting Luncheon of the Texas Medical Association annual session in Houston.

The medical profession and the insurance industry must join in seeing that health insurance is recognized as a means of obtaining the best possible medical care, in using insurance benefits wisely and properly, and in following sound insurance principles. Only through a cooperative relationship will it be possible to continue to serve the needs of the public through voluntary means.

Again, where does insurance fit into the picture? The public will continue to want medical care to be financed through some mechanism which will prevent their paying unexpected medical bills of several hundred dollars or maybe even a bill as small as $50. Witness the fact that 123,000,000 people now have some form of hospitalization insurance, and the number continues to increase rapidly.

Essentially, what the public wants is a budget arrangement for their medical costs. They are willing to pay several dollars each month, but they are not willing to pay a few hundred as infrequently as every few years.

The insurance business has a means of providing the financing of unexpected medical costs. The premiums required are the few dollars a person is willing to pay each month to budget his medical bills.

A WORKING PARTNERSHIP

How are we partners in this endeavor? Before attempting to answer this, let me say that the insurance industry does not have, nor desire a monopoly in insuring medical costs. The Blue Cross organizations are doing a good job, and there are other types of plans in the picture, which is a healthy condition. What a wonderful position for Mr. John Q. Public in buying health insurance! He can choose coverage from the Blue Cross-Blue Shield plans or from a great variety of benefit plans offered by hundreds of insurance companies. There can be no doubt that Mr. John Q. Public's needs and desires would be served

The medication was well tolerated and clean, with excellent patient acceptance.

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to a much lesser degree if either the insurance companies or the Blue Cross organizations had a monopoly on health insurance. In numbers there is strength, and through free competition, greater progress can be expected. The job to be done through voluntary means will tax the imagination, efforts, and energy of all working in the field of insuring medical costs.

Back to the partnership. How do we tie together? I have already said that physicians furnish the medical care and the insurance industry provides a means to help the patient finance this care.

It might be emphasized at this point that the insurance business plays a supporting role in providing the financial mechanism.

We have a dual job to do in educating and convincing the public that good medical care requires complex and costly techniques and facilities, which are of necessity reflected in physicians' fees and hospital bills.

An increasing number of people are buying health insurance every year. Not only are more people purchasing health protection, but they are buying broader coverages. The primary coverage has been protection against hospital bills. The newest form of protection, major medical expense insurance, covers a wide range of medical expenses at home or in the doctor's office as well as in the hospital, and the broad protection of this coverage has been extended to 13,000,000 people—an amazing growth for this newest form of health insurance which was little known 5 years ago.

Thus, with health insurance becoming the principal means by which people finance their medical care, the cost of health insurance inevitably must reflect the rising cost of medical care.

As health insurance costs therefore increase, the public must be convinced that these larger expenditures for health coverage are necessary to provide for more and better medical care—something everyone should want for himself and his family.

Health insurance must be recognized as a means of obtaining the best possible medical care that science can provide, not as a way of spending less for medical care.

If people become unwilling to pay the rising costs of health insurance, it bears directly on the ability of voluntary insurance agencies to carry out the job of financing medical care. Unfortunately there are already some straws in the wind—witness the resistance some Blue Cross organizations are experiencing in trying to get rate increases when the facts clearly indicate that the Blue Cross plans requesting these increases need more money in order to pay hospitals 100 cents for each dollar of service rendered.

The unattractive picture is, of course, the possibility that people may begin to think that the government can do the job more cheaply, and there could be a strong movement in that direction. The government of course cannot do the job at less cost without a deterioration in the quality and quantity of the fine medicine we now enjoy.

RISING COSTS

It is occasionally heard that a good part of our rising costs in health insurance results from abuse, over-utilization, and over-treatment when services are paid for by insurance. I do not believe that this is a very serious influence, for there can be no doubt that the medical societies are able and willing to deal with these problems in a forthright manner.

When we consider over-utilization and increased charges because of the presence of insurance, we again must rely upon the educational processes.

The providers of medical services must understand that insurance does not create new wealth—it merely acts to conserve a single person's resources and to transfer the financial burden from the individual to a group. To use insurance as an excuse to increase fees is but to contribute to the defeat of its purpose and defeat of the voluntary system as well.

To have a full appreciation of these facts and to make the public understand them is a real challenge. As the cost of health insurance rises, requiring premium increases from our policyholders, the insurance business will have numerous opportunities to champion the voluntary system which is bringing the finest medical care to our country, and it expects to do just this.

Now is the time to think about what can be done should the financing of medical care become too great a burden. This proposal is made not with the expectancy that it will become necessary, but rather because addressing ourselves now to possible problems of the future may, by such action, prevent the very problems from becoming realities.

What can we do if faced with the judgment on the part of a great many people that health insurance costs are too high—which, incidentally, means that medical costs are too high?

First, we can exercise every possible control to insure that benefits are used properly and wisely.

Are people being treated in a hospital rather than at home or in a doctor's office just because they have hospitalization insurance? Are extensive and expensive diagnostic tests made when there is insurance but omitted when insurance is not in the picture? These indeed would be practices which could not be justified under the guise of "good medicine."

Second, we can introduce sound insurance principles, thereby using premium dollars where they are most needed.

By sound insurance principles is meant the financing of insurance protection in such a way as to remove pressures for the patient to improve his coverage by electing one type of treatment as compared

with another. Under the ideal plan these pressures are eliminated. The ideal plan should recognize all medical expenses in the same manner, whether in or out of the hospital, whether the treatment involves surgery or not. Such a plan is designed to include a small deductible amount, usually $50, to apply to the very first dollars of expense, thus freeing a great part of the premium to purchase protection against the very large medical bills. Too many health insurance programs provide excellent benefits for the small and medium sized bills, but inadequate benefits for the very large medical bills which can be financially crippling.

The insurance industry has been underwriting plans of the type which have just been described—plans which cover a broad area of medical expenses with a deductible clause to screen out small bills and coinsurance to give the patient a financial interest in the services which he demands. Through coinsurance, the patient becomes a financial partner in his medical expenses; he pays 20 per cent and the plan pays 80 per cent.

No matter how honestly, how intelligently, or how effectively medical care is administered and how well insurance plans are underwritten to finance this care, there will always be those who will advocate that a government operated and financed program will provide better medical care for the average person at less cost.

We know that better medical care for less money is not possible unless we are doing our respective jobs poorly.

It should be apparent to all that we have a 24 hour a day job in keeping the public properly informed in order that they will continue to agree that their needs are best served under our present system.

SENIOR CITIZEN COVERAGE

There are other areas which we must consider and bend every effort to show real progress—specifically, financing of health care for the aged. People of advanced ages have greater need for health protection and smaller funds from which to purchase protection.

Most physicians are familiar with the Forand bill introduced in Congress. It would provide hospitalization and surgical benefits to those eligible for social security and to their beneficiaries. The benefits would be financed through the social security mechanism by increasing payroll taxes on employers and employees.

This bill has the strong support of organized labor, and if it is permitted to become a law, it will provide a means for extension of a governmental financed program to greater and greater numbers of people. It represents more than just the camel's nose under the tent.

The Forand bill will not solve the primary problem of financing medical care for the aged. There are approximately 2,000,000 persons over age 65 who lack the means to pay for their medical care, and the majority of this group would not be covered by the proposed plan.

Considerable progress is being made in providing coverage for older people through our voluntary systems. The Blue Cross organizations have done an outstanding job of extending coverage in this area, and an increasing number of employers are purchasing insurance company programs which provide for the continuation of benefits for retired workers and their dependents. In addition, many companies have raised the eligible age limits for individual policies, some even going to age 75.

Unfortunately, some feel that we are not making progress fast enough. Therefore we must be cognizant of the difficult challenge in the area of financing medical care for our older people.

Any new governmental scheme is certain to be a compromise of free enterprise principles. If we allow these principles to be compromised, the losses in the long run will more than outweigh apparent immediate gains.

COMMON RESPONSIBILITY

Because of the common interests which medicine and health insurance have in many areas, it is important that there be effective communication between us. We need to understand each other's problems.

If differences exist, I can think of no better way to solve them than by having frank discussions in an atmosphere of mutual trust and respect. Success, of course, will not result automatically from a cooperative relationship; nor is a public information program on both our parts the only answer, although, admittedly there needs to be an acceleration of information about the extent and purpose of health insurance through all available channels.

Of more importance, responsibility for preserving freedom of choice, in the final analysis, will rest squarely upon the shoulders of each of us as individuals. Small as our individual contributions may be, multiplied many fold, we can educate and convince the public that continuation of the voluntary way will lead to better and better medical care financed through a system of their own choice.

In accomplishing this, not only will we have maintained a firm foundation for moving forward, but we will have contributed much toward keeping the individual free and independent, which is our American way of life. It behooves each of us to work and strive vigorously and effectively to be sure that medicine and health insurance do not become a responsibility of government.

♦ Mr. Moreen, Vice-President, Group Division, Aetna Life Insurance Company, Hartford 15, Conn.

Femoral Head Replacement Prosthesis

Analysis of Arthroplasties At Hermann Hospital

EDWARD T. SMITH, M.D., and A. ROSS DAVIS, M.D.

Houston, Texas

IN APRIL, 1951, the active orthopedic staff convened at Hermann Hospital to discuss the problem of reconstruction of the hip joint. The discussion at this meeting centered around some means whereby it would be possible for this group to evaluate the Judet[2] method of hip arthroplasty, which was being viewed with great enthusiasm on the continent of Europe and which was rapidly being accepted in this country.

It was decided at that time that this group would adopt the method which employed the acrylic head and adhere to its use alone until such time as would permit its evaluation. For 2 years, only the Judet acrylic type of prosthesis was used, and a total of 33 cases in all were collected.

In 1953, following the visit of Dr. Fred R. Thompson[4] to Texas, it was generally agreed to change to the metal prosthesis, the majority of which were to be the Thompson type of prosthesis. There have been 53 of these cases since that time. This change was made because occasionally the plastic prosthesis broke.[1] Also, it was noted that the stem of the prosthesis had a tendency to migrate out of the shaft of the femur, or in some cases, if the stem was too short, it would migrate down the medullary canal of the femur. In addition to the migration of the prosthesis, gradual absorption and disintegration in the neck of the femur occurred in some of these cases which resulted in a telescoping hip. The Thompson prosthesis was selected because of the material and because the long stem, passing down the shaft of the femur, provided stability.

A total of 97 cases (including 11 other than the 33 Judet acrylic type and the 53 Thompson type previously mentioned) are included in this report, all of which were authenticated by hospital records. It does not include all the cases, only those for which records could be obtained. The great majority of these procedures were performed by members of the active staff of Hermann Hospital, with an occasional case being managed by members of the courtesy staff.

At present, in order of frequency, the indications for the use of the replacement prosthesis are (1) fresh fractures of the femur which are subcapital in type in aged patients, (2) old nonunion of fractures, (3) various arthritic conditions, and (4) replacement for a previous prosthesis which was unsatisfactory.

The contraindications for the use of the femoral head replacement prosthesis are those same ones which would prevent other types of procedures from being done, namely, the presence of infection and patients whose general condition would prohibit any type of surgery being performed. The principal contraindication, however, for the use of the prosthesis at the present time is a young patient.

REVIEW OF SERIES

In this series of 97 patients in whom femoral head replacement prostheses were placed only 2 of the cases were bilateral. The age range was from 13 to 95 years, and the predominant sex was female with a ratio of approximately four to one.

The longest follow-up time since the operation was 78 months and the shortest time was 1 month. The average follow-up time was 30 months. Four of the patients died within 1 month of the time of surgery.

Dr. Edward T. Smith is chief of the orthopedic service at Hermann Hospital in Houston. Dr. A. Ross Davis is an associate on the orthopedic service.

Ninety-seven cases of femoral head replacement prosthesis arthroplasties are reviewed. Patients and their doctors graded results in about half as excellent or good, and the authors suggest that these evaluations may be low. The procedure probably has a greater place in management of fresh fractures than has been considered before.

Twenty per cent of the patients, at the time of follow-up, were walking unaided. Twenty-one per cent were walking with one cane, and 21 per cent were walking with crutches and/or canes. Eleven per cent were not walking and were confined to a wheelchair. Ten per cent were bedridden. This total adds up to 83 per cent and does not include those dying before 1 month and some cases where a follow-up was not obtained.

In evaluating the patients' concept of the results, 15 per cent were graded as excellent. Thirty per cent were graded as good. Twenty-two per cent were graded as fair, and 18 per cent were graded as poor. This was in contrast to the doctors' evaluation of the results which were graded 18 per cent as excellent, 35 per cent as good, 19 per cent as fair, and 13 per cent as poor.

The complications consisted primarily of the following problems: There were 6 cases of dislocation of the prosthesis. There were 3 cases of postoperative infection, and there were 4 deaths in the immediate postoperative period. There was 1 case of fracture of the femur, and an occasional case of gluteus medius lurch. Other complications which were encountered were broken prostheses, excessive calcification in the capsule, and cases of the stem of the prosthesis migrating. In the latter instance, where the stem migrated, it was felt that with the Judet acrylic prosthesis, this was a result of a short stem and absorption of the neck of the femur. With the Thompson prosthesis, the problem has been principally one of mechanics, that is, in preventing the stem from protruding out of the old nail tract where there has been a Smith-Petersen nailing performed previously.

The operative approach used most frequently was the anterior approach, which was used in 59 of the cases listed. There were 22 posterolateral approaches and 16 other approaches. With the posterior approach, the gluteus medius was sectioned and then resutured. In this series, there was no attempt made to remove and replace the greater trochanter. In cases of fresh fractures, the capsule was sutured in nearly every instance, whereas in cases in which there was some arthritis and synovial changes, the capsule was principally excised. In practically every case, sutures were removed in from 7 to 10 days.

In many instances, we did not think that the grading the patient or the physician gave the case was indicative of the great benefit which this procedure had to the patient, due to the fact that many of these patients had associated conditions such as parkinsonism, hemiplegia, severe arthritis, senility, and other problems which could never afford them a good result from any procedure, but which cases were salvageable by means of the use of a femoral head replacement prosthesis. In many of these cases, a prosthesis simplified the nursing care, although it was fairly certain prior to doing the procedure that the patient would never become completely ambulatory. Also, it is well to consider that if the high estimate of failure of hip nailing of acute fractures is accurate, "that is, if the incidence of failure in patients with nonunion or avascular necrosis is 75 per cent, there seems to be little doubt that there is a definite place for the femoral head prosthesis."[3] It was also noted that as a whole, the majority of the cases that were done for arthritis were less satisfactory than the remainder of the cases.

Another important factor which frequently has not been considered before is that the more active the patient was at the time the procedure was done, the more he was dissatisfied with the end result and therefore tended to grade down his evaluation. This was true in many of those which were done for fresh fractures and was believed to be due to the lack of ability on the part of the patient to adjust to his new status and the fact that his hip would never be quite the same as it was prior to his accident.

SUMMARY AND CONCLUSIONS

Observations have been made on the follow-up of 97 cases of femoral head replacement prostheses. When it is considered that this is a salvage procedure, it is felt that as a whole, the results are very good.

Our results tend to point out the fact that this procedure has a far greater place in the management of fresh fractures than has been considered in the past. A great deal of the final evaluation should depend on the patient's over-all status, including his general physical condition and economic welfare.

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Dr. Smith, 501 Hermann Professional Building, Houston.
Dr. Davis, 1022 Hermann Professional Building, Houston.

Time Spent on House Calls

The farthest distance traveled by doctors on house calls and the amount of time they spend making them is discussed in the February 17 issue of *Medical Economics* based on a recent study of 1,200 doctors' house-call habits.

It was found that the typical house call radius varies according to type of locality. The following averages were given: urban areas, 8 miles; suburban areas, 8 miles; metropolitan areas, 10 miles; rural areas, 15 miles. Doctors in all four areas reported that the usual house call takes them approximately 45 minutes, including travel time both ways. The article explains that although the rural physician goes farther, the open roads and open parking spaces of rural areas permit doctors to get where they are going without the long delays imposed by city traffic.

Why People Don't Work

LEO WADE, M.D.

New York, New York

IF A WORKER fails to be present on the job, the chances are that both he and his associates will attribute his absence to sickness. It is true, however, that the worker's conclusion that he is unable to work may have been influenced, consciously or subconsciously, by a number of considerations not directly related to health in the usual sense of the word. Frequent absences are inevitable unless the worker has both the will and the physical ability to work.

FACTORS INFLUENCING WORK ATTENDANCE

Recent studies by my associates and myself,[6-8] as well as by others,[1-5] have called attention to a wide variety of factors which influence the will and the ability of the worker to be on the job. For the purposes of this paper, they will be grouped under two headings: (1) those affecting workers generally or in groups and (2) those affecting individual workers.

GROUP OF WORKERS

Adverse economic circumstances are likely to be times of high work attendance while "boom" times are associated with increased absenteeism. Dr. Norman Plummer, medical director of the New York Telephone Company, found that absenteeism ranged from a low of 1.5 per cent of the scheduled working time during the depression of the early thirties to approximately 5 per cent in the latter part of World War II.

There were no demonstrable periods of epidemic disease or "surges" of good health. The attendance pattern seems to reflect the acute realization on the part of the average worker of the probable availability or nonavailability of other jobs.

Epidemic or endemic disease beyond the control of individuals or even groups of individuals may lead to elevated absenteeism rates. The recent concern regarding the possibility of an influenza epidemic is a case in point. Certainly there can be no doubt that absenteeism during the 1918 epidemic was considerable.

Endemic disease may increase in prevalence from time to time and become so common a cause of disability among workers as to simulate epidemic disease. For example, the occurrence of malaria among a working population of a foreign affiliate of the Standard Oil Company of New Jersey was the basis for excessive absenteeism rates over a number of years. Only public health control measures (the eradication of mosquitoes capable of transmitting the disease) were effective in reducing the incidence of temporary disability.

This paper is based on a presentation made by Dr. Leo Wade, medical director of Esso Standard Oil Company, New York, at the tenth annual Health Conference on Business and Industry held in Houston September 26-28, 1957.

Unwarranted "sickness" absenteeism is frequently associated with emotional, domestic, social, or economic problems. These factors can be partly eliminated by the joint effort of management and supervisory personnel and the plant physician.

Upper respiratory tract infections and gastrointestinal disturbances are blamed for much of the absenteeism in this country. Control measures are to no avail because of a lack of basic knowledge concerning the true etiology of these diseases and their mode of spread. This lack of knowledge makes these diagnoses convenient "waste basket" categories for many workers and their physicians where medical certification of an otherwise inexplicable absence is required. The true significance of these disease groups as a legitimate cause of sickness absenteeism is not known.

Climatic conditions affect absenteeism patterns of employee groups both directly and indirectly. A study in one domestic refinery showed an inverse relationship between the mean daily temperature and the absenteeism rate. Other climatic circumstances may also affect the worker's ability and desire to be on the job.

Working conditions may deteriorate in the absence of effective safety and hygiene programs. Wherever proper personnel and training techniques are maintained, industrial accidents and sickness have all but been eliminated even in traditionally hazardous occupations and trades.

Provision of appropriate and adequate medical services has been recommended as a "sure-fire" remedy for excessive absenteeism rates. In one refinery a direct relationship existed between the number of visits to the plant dispensary and the cost of sickness absenteeism.

In another location, however, careful observations over a 3 year period revealed that more than 12 per cent of the absences (25 per cent of working days lost) were recommended by the medical department

as a result of findings at the time of periodic health examination. In many instances, these absences were for defects that previously were unrecognized by the individual employees. In other instances, the worker had no plans for remedial therapy. Such activity probably decreases the total lost time for employees on a career basis, but this cannot be documented. Certainly the absence can be better timed for the employer's convenience, and correction of defects should increase the effectiveness or productivity of the individual employee.

Management attitudes and practices obviously are reflected in employees' attitude toward their jobs. Newspaper accounts during the past few years have reported epidemics of "sickness" absenteeism at times of management-labor disputes. Usually the situation is far more subtle. Poor communications, failure to emphasize the positive aspects of employment, overstaffing, and many other well known factors may affect employee group morale adversely.

The variations in the attendance records of employees of different departments in the same plant suggest differences in supervisory attitudes and, hence, employee morale or "will" to be on the job. In one department, for example only about 30 per cent of the employees had a perfect attendance record while some were absent as many as 6 times. In contrast, in a second department more than 60 per cent of the employees had a perfect attendance record with none absent more than 4 times. There were no differences in the potential health hazards associated with work in the two departments and no demonstrable difference in the general health status of the men.

This is not meant to be an exhaustive list. It is intended merely to emphasize that there are important causative factors beyond the control of individual employees, supervisors, and doctors. This does not imply that one cannot cope with such influences, but it is essential to recognize that excessive absenteeism may involve considerations other than strictly medical considerations referable to the health of the individual worker.

INDIVIDUAL WORKERS

The true health status of the worker is obviously a primary consideration. While this may be so obvious as to seem trite, the statement is almost without meaning. Many workers with rather serious health problems may have perfect work attendance, while others seemingly in robust health may have considerable and even excessive "sickness" absenteeism. Some of the apparent disparity arises from our limited concepts of health and disease.

The alleged causes of "sickness" absenteeism among employees over a 2 year period are shown in table 1.

Respiratory and gastrointestinal disease accounted for roughly 75 per cent of the absences and 50 per cent of the time lost. While some of these absences were clearly bona fide and, in many instances, necessitated by even serious disease, more frequently the need for the absence could not be documented. Certainly in most instances no objective evidence could be produced that the total health status of most of these employees was poorer than those who were not absent for these or any other reasons.

TABLE 1.—*Alleged Causes of "Sickness" Absenteeism Among Employees.*

Cause	% of Absence	
	Number	Days Lost
Respiratory disease	47.7	29.9
Gastrointestinal disease	26.0	17.7
Musculoskeletal disease	5.2	7.9
Cardiovascular disease	1.6	14.1
Other sickness	14.9	20.7
Nonindustrial accidents	3.3	6.3
Industrial accidents	1.3	3.4

Age and sex appear to have certain inevitable effects on job attendance, at least in the present state of medical knowledge. Female employees are absent 2 to 3 times as frequently as male employees, but the average absence is less than half as long for the female employee. The net result is approximately the same average number of days lost per year for employees of either sex.

There is a tendency for absences to be less frequent with advancing age but more prolonged, particularly in the case of the male employee. The major cause of this phenomenon is the almost inevitable onset of serious cardiovascular or neoplastic disease with increasing age and a decreased need (or desire) for repeated short term absences for minor illness.

Proper job assignment involves many things. Assuming the employee has the physical capacity to do the job assigned, it also is necessary that he have the aptitude and desire to do that kind of work. The work load must be such as to keep him under mild, but not excessive pressure. The worker must have some evidence that what he is doing is important and that someone in authority appreciates his doing it well.

Off-the-job activities and avocations should be entered into and pursued with the same attention to safety and health factors given job activities. Nonindustrial accidents are becoming increasingly frequent causes of lost time. Highway accidents and "do-it-yourself" mishaps are particularly important in this regard. Then, too, one occasionally finds employees who have been severely restricted so far as physical activity on the job is concerned engaging in strenuous activities or even competitive sports off the job.

Many workers engage in part-time or even full-time employment with other companies ("moonlighting"). Employees with small farms sometimes

consider seasonal off-the-job obligations more important than those on the job. A heavy schedule at night school or a crisis in the local school board or volunteer fire department also may lead to exhaustion from sheer lack of rest and relaxation.

The home or living conditions may affect adversely job attendance by many devious means. Proper housing, hygiene, and nutrition obviously are conducive to health maintenance. Illness or invalidism in the family, lack of domestic help where both parents are employed, and even clandestine love affairs have been underlying problems in some instances.

Motivation of individuals is almost impossible to assess but is a powerful influence on work attendance. A chronically ill widow who is the sole support of several small children will often work to her own detriment even in the presence of serious disease whereas a young girl who lives at home will be completely incapacitated for several days by mild dysmenorrhea. Liberal benefit programs, compensation laws, or tax advantages may influence the employee's evaluation of his ability to work. Emotional and social needs supplied by a job will also keep many on the job when they might otherwise be at home. The individual's philosophy of life, religious convictions, sense of loyalty to fellow workers, and his employer also may be motivating forces.

"SICKNESS" ABSENTEEISM AND ITS REDUCTION

The following useful conclusions regarding "sickness" absenteeism may be reached:

1. "Sickness" absenteeism tends to be chronic among a relatively small segment of the employee population.

2. Bona fide illness may be the cause of chronic absenteeism, but does not justify nor necessitate the acceptance by management of poor job attendance. Corrective medical measures, reassignment to duties in keeping with capacities, or separation from the service are to be considered.

3. Unwarranted "sickness" absenteeism is more frequently associated with emotional, domestic, social, or economic problems. In such instances, illness, if it does exist, is merely an alibi for the irregular job attendance.

4. A certain minimal amount of "sickness" absenteeism is inevitable. Where possible this absenteeism should be controlled and directed in the interest of the continued health and productivity of the individual employee, as well as in the interest of the continued health and safety of fellow workers.

In almost all industrial installations, absenteeism costs can be reduced. If the approach to this goal is an intelligent one, there should be no adverse effect upon employee health. In fact, there might be an improvement in employee health and usually in employee morale. This goal cannot be accomplished, however, by a directive to the medical department, for it requires the dedicated and enthusiastic leadership of management and supervisory personnel with the courage to act when all the pertinent data have been assembled.

Since the problem is concentrated in a relatively small segment of the employee population, the first and obvious step is to identify this group. Record keeping is a basic requirement. Depending upon the size of the employee population and the available personnel, one might review the 5, 3 or 1 per cent of workers with the poorest work attendance. This should be done on a departmental, section, or craft basis at first so that variations in the prevalence of absenteeism within the plant may be apparent. In this way, attention can be directed toward the possibility that group factors, such as improper supervision, public health problems, and job hazards, are influencing work attendance adversely.

If poor work attendance is characteristic of groups of employees working in the same division or department or engaged in similar kinds of work, a careful consideration of the working and living conditions should be undertaken first. The plant physician and the local health officers should know of epidemic or endemic disease of sufficient prevalence to account for the excessive loss of time. Knowledge and techniques to cope with such situations almost invariably are available. Excessive occupational injury or disease also should be known by the medical department. Appropriate safety and hygiene measures are available. Industrial relations problems, employee relations problems, supervisor-employee relations problems, and others may or may not be apparent at the outset. All such problems or potential ones should be examined prior to embarking upon a detailed, laborious, and time consuming study of individual attendance problems.

In the absence of clear-cut group factors, the only effective means of combating unwarranted absenteeism is by careful evaluation of suspected offenders on an individual basis and followup with indicated corrective measures. It must be emphasized here, however, that attention is being directed to the attendance pattern of individual employees and not to individual absences. Forceful action based upon an effort to evaluate the reasonableness of any single absence—past, present, or future—may lead layman and physician alike into embarrassing and untenable positions.

Simultaneously, but independently, the supervisor and the plant physician should assemble the necessary information to answer certain questions. Of course, of primary concern is the worker's health status. Most adults have one or more physical defects. These need not be chronically nor intermittently incapacitating provided the worker takes proper care of himself and is assigned to a job within his capabilities. If real bona fide disability does exist, then proper treatment and rehabilitation should be instituted. Although this is a strictly medical problem, management backing and guidance often is necessary. For various reasons, the worker may evade proper treatment or may resist attempts to redirect his therapeutic efforts along more nearly constructive lines. Only when management indicates that it is essential that his defect be corrected if he is to retain his job will some workers make a serious effort to abide by medical guidance.

If the defect is not correctible or resists medical measures or if the employee chooses not to abide by proper medical guidance and advice, reassignment to more nearly appropriate tasks or separation from the job is indicated. This may seem to be a harsh and cruel decision, but actually it is not. Any of us who has had occasion to work with truly disabled people is quite aware of the fact that very few want sympathy and charity; they inevitably want an opportunity to show that they can do a job and do it well. Most such persons are acutely unhappy when placed in situations where they cannot do their honest share of the work.

Reassignment to another job is often difficult. There can be no doubt, however, that few disabled people, even those with serious disability are incapable of doing some kind of productive work under some conditions. Assuming that it is practicable for the disabled worker to get to and from the plant or office daily, there is a need to define specifically what the employee can and cannot do. Too frequently, a glib recommendation of light work by the doctor has left the worker without a job or in a useless assignment. The physician can and must be more specific, and management, too, needs to define job requirements in a specific manner. In all instances, however, a trial at the new assignment should clarify any doubts as to the reasonableness of the decision.

The much maligned and overworked supervisor is a key man in the absenteeism problem. His close working relations with the individual employee place him in the best position to evaluate the motivation of the employee. Job performance and changes in it may be invaluable clues to basic causes of poor work attendance. Promotions, or lack thereof, within the department, work assignments, the introduction of new employees into the group, changes in job content, variations in work load, and innumerable other factors may influence the worker's desire to be on the job in the presence of a headache or other minor ailment.

The pattern of absenteeism also may give valuable clues. Seasonal demands on the part-time gardener or farmer, holiday or week-end temptations for alcoholics, and similar intermittent stresses and strains on the worker's availability for his regular job may be best detected in this way. Expiration of sickness benefits also may influence the ability to withstand minor illness or complaint.

Both the physician and the supervisor must approach each problem case with an open mind prepared to study and evaluate new and unsuspected factors. The two should meet at intervals with personnel officers and other management people to discuss the cases one by one. Existing personnel policies and programs may need revision. Implementation of present or new policies often requires the cooperative effort of management and union representatives. The attitude of the union groups has been constructive wherever factual information justified the course of action chosen.

Unwarranted and excessive sickness absenteeism resembles many other human problems in that it tends to be chronic. The solution of the problem is not a "one shot" proposition. A few of the current employees with good attendance records, as well as newly hired employees, will become the problems of tomorrow. A continuing review of job attendance is necessary if optimal attendance is to be maintained.

Does such an approach pay off? Sickness absenteeism costs had been creeping upward over a period of years in one large plant: the cost for wage earners absence had reached almost 4.5 per cent of payroll for the year 1951. With enthusiastic implementation of the program outlined previously late in 1951 and early in 1952, there began a downward trend in such costs which continued at a fairly constant rate for a 2 year period. Subsequent decline has been at a reduced rate for obvious reasons.

CONCLUSION

Absenteeism costs can be reduced by a joint effort on the part of management and supervisory personnel with the collaboration of the plant physician. There is another and often unexpected reward for those who undertake a constructive program for the control of unwarranted absenteeism. This same minority group will be found to include most of the problem drinkers, the nonproductive and disgruntled employees who are a drain on employee morale, the

accident-prone workers, and other categories of employees who are a constant source of problems to supervisory and management personnel.

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♦ Dr. Wade, Medical Director, Esso Standard Oil Company, New York, N. Y.

MEDICAL NEWS

★ Coming Meetings

Texas Medical Association, San Antonio, April 18-21, 1959 (Executive Council, Sept. 7, 1959). Dr. Howard O. Smith, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Exec. Secy.

American Medical Association, Clinical Meeting, Minneapolis, Dec. 2-5, 1958. Dr. Gunnar Gundersen, La Crosse, Wis., Pres.; Dr. F. J. L. Blasingame, 535 North Dearborn, Chicago 10, Exec. Vice-Pres.

Current Meetings

JULY

Fifth and Sixth Districts Society, Corpus Christi, July 11-12, 1958. Dr. Foy Moody, Corpus Christi, Pres.; Dr. Thelma Frank, 1314 16th St., Corpus Christi, Secy.

Twelfth District Society, Waco, July 8, 1958. Dr. George C. Bryant, Waco, Pres.; Dr. J. T. Archer, Jr., Meridian, Secy.

Postgraduate Medical Assembly of South Texas, Houston, July 21-23, 1958. Dr. Charles D. Reece, Pres.; Dr. C. Forrest Jorns, Secy., Exec. Office, 412 Jesse Jones Library Bldg., Houston 25.

AUGUST

American Congress of Physical Medicine and Rehabilitation, Philadelphia, Aug. 24-29, 1958. Dr. Donald L. Rose, Kansas City, Kan., Pres.; Dorothea C. Augustin, 30 N. Michigan Ave., Chicago, Executive Secretary.

American Hospital Association, Chicago, Aug. 18-21, 1958. Mr. Tol Terrell, San Angelo, Pres.; Dr. Edwin L. Crosby, 18 E. Division, Chicago 10, Executive Director.

National and Regional

American Academy of Allergy, Chicago, Feb. 9-11, 1959. Dr. Max Samter, Chicago, Pres.; Dr. Bram Rose, Royal Victoria Hospital, Montreal, Canada, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 6-11, 1958. Dr. James R. Webster, Chicago, Pres.; Dr. R. R. Kierland, Mayo Clinic, Rochester, Minn., Secy.

American Academy of General Practice, San Francisco, April 6-9, 1959. Dr. Holland T. Jackson, Fort Worth, Pres.; Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Executive Secy.

American Academy of Obstetricians and Gynecologists. Dr. R. Gordon Douglas, New York, Pres.; Dr. John C. Ullery, Ohio State University Hospital, Columbus, Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 12-17, 1958. Dr. LeRoy A. Schall, Boston, Pres.; Dr. W. L. Benedict, 15 Second St. S.W., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 20-23, 1959. Dr. Stewart H. Clifford, Brookline, Mass., Pres.; Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Secy.

American Association for Maternal and Infant Health, 1960. Mr. Howard I. Wells, Jr., 116 S. Michigan Ave., Chicago 3, Executive Secy.

American Association for Thoracic Surgery, Los Angeles, April 21-23, 1959. Dr. Michael E. DeBakey, Houston, Pres.; Dr. Hiram T. Langston, 600 S. Kingshighway, St. Louis 10, Secy.

American Association of Genito-Urinary Surgeons. Dr. George F. Cahill, New York, Pres.; Dr. W. J. Engel, 2 East 54th, New York 22, Secy.

American Association of Obstetricians and Gynecologists, Hot Springs, Va., Sept. 4-6, 1958. Dr. William F. Mengert, Chicago, Pres.; Dr. E. Stewart Taylor, University of Colorado School of Medicine, 4200 E. 9th, Denver, Secy.

American Cancer Society, New York, Oct. 29-31, 1958. Dr. L. T. Coggeshall, Chicago, Pres.; M. R. Runyon, 521 W. 57th, New York, Executive Vice-Pres.

American College of Allergists, San Francisco, March 15-20, 1959. Dr. Merle W. Moore, Portland, Ore., Pres.; Dr. M. Coleman Harris, 450 Sutter St., San Francisco, Secy.

American College of Chest Physicians. Dr. Burgess L. Gordon, Philadelphia, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut, Chicago 11, Executive Secy.

American College of Gastroenterology, New Orleans, Oct. 19-25, 1958. Dr. C. Wilmer Wirts, Philadelphia, Pres.; Mr. Daniel Weiss, 33 West 60th, New York 23, Executive Director.

American College of Physicians, Chicago, April 20-24, 1959. Dr. Dwight L. Wilbur, San Francisco, Pres.; Mr. E. R. Loveland, 4200 Pine, Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 6-7, 1959. Dr. Vincent W. Archer, Charlottesville, Va., Pres.; Mr. W. C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

American College of Surgeons, Chicago, Oct. 6-10, 1958. Dr. William L. Estes, Bethlehem, Pa., Pres.; Dr. Michael L. Mason, 40 E. Erie, Chicago 11, Secy.

American Dermatological Association. Dr. Clark W. Finnerud, Chicago, Pres.; Dr. Hamilton Montgomery, 200 1st, S.W., Rochester, Minn., Secy.

American Gastro-Enterological Association. Dr. F. J. Ingelfinger, 65 E. Newton, Boston 18, Secy.

American Gynecological Society, Hot Springs, Va., May 25-27, 1959. Dr. Lewis C. Scheffey, Philadelphia, Pres.; Dr. A. A. Marchetti, George Washington University Hospital, Washington 7, D. C., Secy.

American Heart Association, San Francisco, Oct. 24-28, 1958. Dr. Robert W. Wilkins, New York, Pres.; Mr. John D. Brundage, 44 E. 23rd, New York 10, Secy.

American Laryngological, Rhinological, and Otological Society, Hot Springs, Va., March 10-12, 1959. Dr. G. D. Hoople, Syracuse, N. Y., Pres.; Dr. C. S. Nash, 708 Medical Arts Bldg., Rochester, N. Y., Secy.

American Neurological Association. Dr. Israel S. Wechsler, New York, Pres.; Dr. Charles Rupp, 133 S. 36th, Philadelphia 4, Secy.

American Ophthalmological Society, Hot Springs, Va., May 28-30, 1959. Dr. Derrick Vail, Chicago, Pres.; Dr. M. C. Wheeler, 30 W. 59th, New York 19, Secy.

American Orthopedic Association. Dr. George O. Eaton, Baltimore, Pres.; Dr. Harold A. Sofield, 715 Lake St., Oak Park, Ill., Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 6-8, 1959. Dr. Joseph Stokes, Jr., Philadelphia, Pres.; Dr. A. C. McGuinness, Room 1036, 2800 Quebec St., N.W., Washington 8, D. C., Secy.

American Proctologic Society. Dr. Julius E. Linn, Birmingham, Pres.; Dr. Norman D. Nigro, 10 Peterboro, Detroit 1, Secy.

American Psychiatric Association, Philadelphia, April 26-May 1, 1959. Dr. Francis J. Gerty, Chicago, Pres.; Dr. C. H. Hardin Branch, 156 Westminister Ave., Salt Lake City, Secy.

American Public Health Association, St. Louis, Oct. 27-31, 1958. Roy J. Morton, Oak Ridge, Tenn., Pres.; Dr. Berwyn F. Mattison, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Pittsburgh, Pa., Oct. 19-24, 1958. Dr. Ralph S. Sappenfield, Miami, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph, Chicago 1, Secy.

American Society of Clinical Pathologists, Chicago, Nov. 1-8, 1958. Dr. Harry P. Smith, New York, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan, Indianapolis 7, Secy.

American Surgical Association. Dr. John H. Mulholland, New York, Pres.; Dr. William Altemeier, Christian R. Holmes Hospital 19, Cincinnati, Secy.

American Urological Association, Atlantic City, April 20-23, 1959. Dr. Adolph Kutzmann, Los Angeles, Pres.; Dr. Samuel L. Raines, 188 S. Bellevue Blvd., Memphis, Tenn., Secy.

Association of American Physicians and Surgeons, Interim Meeting, Chicago, Oct. 10-11, 1958. Dr. Mal Rumph, Fort Worth, Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Dr. Curtice Rosser, Dallas, Pres.; Dr. Karl Meyer, 1516 Lake Shore Dr., Chicago, Secy.

National Tuberculosis Association, Chicago, May 24-29, 1959. Dr. Mario M. Fischer, Duluth, Minn., Pres.; Mrs. Wallace B. White, 651 Marlborough Rd., Brooklyn 30, Secy.

Radiological Society of North America, Chicago, Nov. 16-21, 1958. Dr. Leo G. Rigler, Los Angeles, Pres.; Dr. Donald S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, New Orleans, Nov. 3-6, 1958. Dr. W. Kelly West, Oklahoma City, Pres.; Mr. V. O. Foster, 1020 Empire Bldg., Birmingham 3, Secy.

Southern Surgical Association, Boca Raton, Fla., Dec. 9-11, 1958. Dr. James D. Rives, New Orleans, Pres.; Dr. George G. Finney, 2947 St. Paul, Baltimore 18, Secy.

Southern Psychiatric Association, Tennessee, October, 1958. Dr. Frank Luton, Nashville, Pres.; Dr. Iverson O. Brownell, Greenville, S. C., Secy.

Southwest Allergy Forum, Houston, April 26-28, 1959. Dr. Richard L. Etter, Houston, Pres.; Dr. Richard H. Jackson, 156 Hermann Professional Building, Houston, Secy.

Southwest Regional Cancer Conference, Fort Worth, September, 1958. Dr. O. J. Wollenman, Jr., Fort Worth, Chm.; Mrs. Ira Frances Ball, 264 W. 11th, Fort Worth, Secy.

Southwestern Medical Association, Tucson, Ariz., Oct. 23-25, 1958. Dr. Louis G. Jekel, Phoenix, Pres.; Dr. Russell L. Deter, 1501 Arizona, El Paso, Secy.

Southwestern Society of Nuclear Medicine. Dr. Jack G. S. Maxfield, Dallas, Pres.; Dr. J. R. Maxfield, Jr., 311 Medical Arts Bldg., Dallas, Secy.

Southwestern Surgical Congress, Denver, March 30-April 2, 1959. Dr. Louis M. Overton, Albuquerque, Pres.; Mary O'Leary, 813 Medical Arts Bldg., Oklahoma City, Exec. Secy.

Tri-State Medical Assembly, Shreveport, Sept. 18, 1958. Dr. James Gatline, Camden, Ark., Pres.; Dr. Jason Sanders, Sanders Clinic, Kings Highway, Shreveport, La., Secy.

United States-Mexico Border Public Health Association, Brownsville and Matamoros, Tamaulipas, Mexico, April, 1959. Albert O. Irigoyen, Mexico, D. F., Pres.; Dr. Jorge Román, 243 United States Court House, El Paso, Secy.

State

Private Clinics and Hospitals Association of Texas, Dallas, Dec. 14-15, 1958. Dr. Joe Shepperd, Burnet, Pres.; Mr. Henry E. Taylor, Medical Arts Building, Dallas, Executive Secy.

Texas Academy of General Practice, San Antonio, Sept. 22-24, 1958. Dr. G. W. Cleveland, Austin, Pres.; Mr. Donald C. Jackson, 1905 N. Lamar, Austin, Executive Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 6-7, 1958. Dr. A. W. Harris, Dallas, Pres.; Dr. Hugo T. Engelhardt, 1216 Main, Houston, Secy. Meetings restricted to members.

Texas Air-Medics Association, San Antonio, April, 1959. Dr. R. Henry Harrison, Bryan, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Austin, February, 1959. Dr. Louis J. Manhoff, Jr., San Antonio, Pres.; L. Ruth Guy, Ph.D., 725 Doctors Building, Temple.

Texas Association for Mental Health, Fort Worth, March 12-14, 1959. Dr. Frank Schooner, Fort Worth, Pres.; Mr. John Lane, 2410 San Antonio, Austin, Executive Director.

Texas Association of Obstetricians and Gynecologists, Fort Worth, Feb. 14, 1959. Dr. Jesson L. Stowe, El Paso, Pres.; Dr. Oran V. Prejean, 1317 N. Washington St., Dallas, Secy.

Texas Chapter, American Association of Public Health Physicians, San Antonio, April, 1959. Dr. David M. Cowgill, San Benito, Pres.; Dr. B. M. Primer, 2709 Rio Grande, Austin.

Texas Chapter, American College of Chest Physicians, San Antonio, April 19, 1959. Dr. J. O. Armstrong, Dallas, Pres.; Dr. Carlos J. Quintanilla,, Box 592, Harlingen, Secy.

Texas Club of Internists. Dr. D. D. Warren, Waco, Pres.; Dr. L. C. Carter, 2600 Procter, Port Arthur, Secy.

Texas Dermatological Society, San Antonio, April 20, 1959. Dr. Earl L. Loftis, Dallas, Pres.; Dr. E. N. Walsh, 1410 Pruitt St., Fort Worth 4, Secy.

Texas Diabetes Association, San Antonio, April 19, 1959. Dr. Merton Minter, San Antonio, Pres.; Dr. Warren W. Moorman, 901 W. Leuda, Fort Worth, Secy.

Texas Division, American Cancer Society, Austin, Dec. 4, 1958. Dr. J. Layton Cochran, San Antonio, Pres.; Mr. Curt W. Reimann, 5014 Bull Creek Rd., Austin 3, Executive Director.

Texas Geriatrics Society, San Antonio, April 20, 1959. Dr. Martin S. Buehler, Dallas, Pres.; Dr. J. A. Armstrong, 3810 Swiss Ave., Dallas, Secy.

Texas Heart Association, San Antonio, April 19, 1959. Dr. William B. Adamson, Abilene, Pres.; Ernest T. Guy, 404 Jesse H. Jones Library Bldg., Texas Medical Center, Houston 25, Executive Director.

Texas Hospital Association, Houston, May 11-14, 1959. Mr. W. P. Earngey, Jr., Fort Worth, Pres.; Mr. O. Ray Hurst, 2208 Main, Dallas, Executive Director.

Texas Industrial Medical Association, San Antonio, April 19, 1959. Dr. Wendell H. Hamrick, Houston, Pres.; Dr. Robert A. Wise, Box 2180, Houston, Secy.

Texas Neurophychiatric Association, San Antonio, April 19, 1959. Dr. Samuel R. Snodgrass, Galveston, Pres.; Dr. Clarence S. Hoekstra, 8215 Westchester Drive, Dallas, Secy.

Texas Ophthalmological Association, San Antonio, April 19, 1959. Dr. Harold Beasley, Fort Worth, Pres.; Dr. James Scruggs, 2223 Austin, Waco, Secy.

Texas Orthopedic Association, San Antonio, April 20, 1959. Dr. Louis J. Levy, Fort Worth, Pres.; Dr. Margaret Watkins, 3503 Fairmount, Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 17-18, 1958. Dr. T. J. McElhenney, Austin, Pres.; Dr. James N. Walker, 5216 W. Freeway, Fort Worth, Secy.

Texas Physical Medicine and Rehabilitation Society, San Antonio, April 19, 1959. Dr. Vann S. Taylor, Dallas, Pres.; Dr. Lewis A. Leavitt, Veterans Administration Hospital, Houston, Secy.

Texas Proctologic Society, February, 1959. Dr. C. P. Hardwicke, Austin, Pres.; Dr. H. Gray Carter, 915 St. Joseph St., Dallas, Secy.

Texas Public Health Association. Dr. D. R. Reilly, San Angelo, Pres.; Mr. Wayne Garrett, City Health Department, Fort Worth, Executive Secy.

Texas Radiological Society, Dallas, Jan. 30-31, 1959. Dr. R. F. Wertz, Amarillo, Pres.; Dr. J. E. Miller, 6407 Forest Lane, Dallas 30, Secy.

Texas Rheumatism Association, Galveston, Dec. 5, 1958. Dr. W. W. Bondurant, San Antonio, Pres.; Dr. J. Morris Horn, 3707 Gaston, Dallas, Secy.

Texas Society of Anesthesiologists, San Antonio, April 19, 1959. Dr. M. M. Rosenzweig, San Antonio, Pres.; Dr. M. T. Jenkins, Parkland Hospital, Dallas, Secy.

Texas Society of Athletic Team Physicians, San Antonio, April 18, 1959. Dr. Edward T. Smith, Houston, Pres.; Dr. Jack Brannon, 2715 Fannin, Houston, Secy.

Texas Society of Gastroenterologists and Proctologists, San Antonio, April 19, 1959. Dr. O. P. Griffin, 800 5th Avenue, Fort Worth, Pres.; Dr. A. C. Broders, Jr., Scott and White Clinic Hospital, Temple, Secy.

Texas Society of Ophthalmology and Otolaryngology, Houston, Dec. 5-6, 1958. Dr. Owen R. O'Neill, Paris, Pres.; Dr. Edwin G. Grafton, 4319 Oak Lawn, Dallas, Secy.

Texas Society of Pathologists, San Antonio, April 21, 1959. Dr. John H. Childers, Galveston, Pres.; Dr. Marvin H. Grossman, Box 57, Dallas, Secy.

Texas Society of Plastic Surgeons, San Antonio, April 18, 1959. Dr. Baron Hardy, Houston, Pres.; Dr. Raymond Brauer, 6615 Travis, Houston, Secy.

Texas Surgical Society, Galveston, Oct. 6-7, 1958. Dr. J. Peyton Barnes, Houston, Pres.; Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple, Secy.

Texas Traumatic Surgical Society, San Antonio, April 19, 1959. Dr. G. V. Brindley, Temple, Pres.; Dr. W. E. Crump, 1300 Eighth, Wichita Falls, Secy.

Texas Tuberculosis Association, San Antonio, March 19-21, 1959. Dr. John W. Middleton, Galveston, Pres.; Miss Pansy Nichols, P. O. Box 6158, Austin 21, Executive Director.

Texas Urological Society, San Antonio, January, 1959. Dr. Charles Hooks, Galveston, Pres.; Dr. Charles Hulse, 636 Moore Building, San Antonio.

District

First District Society, Fort Stockton, February, 1959. Dr. H. D. Garrett, El Paso, Pres.; Dr. E. S. Crossett, 1501 Arizona St., El Paso, Secy.

Second District Society, Lamesa. Dr. J. Vernon McKay, Lamesa, Pres.; Dr. Noble L. Rumbo, Box D, O'Donnell, Secy.

Third District Society, Plainview, March, 1959. Dr. Robert H. Mitchell, Plainview, Pres.; Dr. H. Fred Johnson, 2308 W. Eighth, Amarillo, Secy.

Fourth District Society, San Angelo, Oct. 19, 1958. Dr. Fred D. Spencer, Brownwood, Pres.; Dr. W. Lacey Smith, 111 E. Harris, San Angelo, Secy.

Seventh District Society. Dr. Robert N. Snider, Austin, Pres.; Dr. Richard Lucas, 502 W. 13, Austin, Secy.

Eighth District Society, Galveston, October, 1958. Dr. John H. Childers, Galveston, Pres.; Dr. M. Warren Hardwick, 839 E. Mulberry, Angleton, Secy.

Ninth District Society, Huntsville. Dr. Lyman C. Blair, Houston, Pres.; Dr. James H. Sammons, Highlands, Secy.

Tenth District Society, Beaumont, Nov. 11, 1958. Dr. B. F. Pace, Beaumont, Pres.; Dr. W. J. Poshataske, Silsbee, Secy.

Eleventh District Society, May, 1959. Dr. Ben Wilson, Tyler, Pres.; Dr. Phillip W. Taylor, 833 S. Beckham, Tyler, Secy.

Thirteenth District Society, Wichita Falls, 1959. Dr. W. R. Sibley, Abilene, Pres.; Dr. R. D. Moreton, 1217 W. Cannon, Fort Worth, Secy.

Fifteenth District Society. Dr. Charles Wise, Naples, Pres.; Dr. George Bennett, 402 S. Bolivar, Marshall, Secy.

Clinics

Blackford Memorial Cancer Lectures, Denison, Nov. 11, 1958. Dr. R. G. Gerard, 509 S. Mirick, Denison, Chm.

Dallas Southern Clinical Society, Dallas, March 23-25, 1959. Dr. C. D. Bussey, Dallas, Pres.; Millard J. Heath, 433 Medical Arts Bldg., Dallas 1, Executive Officer.

International Medical Assembly of Southwest Texas, San Antonio, January, 1959. Dr. Lawrence B. Reppert, 817 South Texas Bldg., San Antonio, Secy; S. E. Cockrell, 202 W. French Place, San Antonio, Exec. Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 2-5, 1959. Dr. Eugene H. Countiss, New Orleans, Pres.; Dr. Maurice E. St. Martin, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Oct. 18, 1958. Dr. J. B. Hathorn, Jr., 1500 8th, Wichita Falls, Chm.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 27-29, 1958. Dr. Herman Fagin, Oklahoma City, Pres.; Miss Alma F. O'Donnell, 503 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Board Examinations

Texas State Board of Examiners in Basic Sciences, Austin, Oct. 13-14, 1958. Henry B. Hardt, Ph.D., Fort Worth, Pres.; Mrs. Betty J. Anderson, Chief Clerk, 303 East Seventh, Austin.

Texas State Board of Medical Examiners, Fort Worth, Dec. 4-6, 1958. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.; Miss Luanna Knox, Assistant Secy.

MEDICOLEGAL NOTES

Common Law Marriages Can Be Problem for Physicians

On numerous occasions physicians in Texas are confronted with situations which necessitate their understanding of the law as it relates to what are called common law marriages.

A good example of a situation which may raise certain legal questions concerning common law marriages was presented not too long ago when a physician was filling out the necessary information to complete a birth certificate. The physician was requested by the mother to enter the name of a certain male as being the father of the child. The physician knew, however, that the mother of the child was, in fact, unwed. The question presented was whether or not he should enter the name of the father upon the birth certificate.

Article 4477, Rule 47a, V. A. C. S., which deals with the form and contents of birth certificates, states:

> "The standard certificate of birth shall be in such form and shall provide for such items of information as may be prescribed by the State Department of Health. All items prescribed on the certificate of birth are hereby declared necessary for the legal, social and sanitary purposes subserved by registration records. Provided that the name of the father, or any information by which he might be identified, shall not be written into the birth or death certificate of any illegitimate child; and provided further, that any statement that the father of an illegitimate child wishes to make as to its parentage may, when placed in the form of an affidavit, be attached to the original birth record. The state registrar, county clerk, or local registrar shall not issue a certified copy disclosing illegitimacy or otherwise disclose illegitimacy unless the issuance of the certified copy or the disclosure is authorized by order of the county court of the county in which the birth, death, or fetal death occurred."

As can be seen by a reading of the above statute, it is forbidden expressly by law for a physician or for anyone else to enter upon the birth certificate of an illegitimate child either the name of the father or any information by which he might be identified. The question as to whether the father's name is to be entered or not is determined by whether or not the child is, in fact, illegitimate.

Illegitimacy is a term applied to the status of a child to denote that it was not conceived or born in lawful wedlock. Of course there are certain instances when this definition of illegitimacy would be considered overly restrictive because there are certain situations whereby a child can be conceived and born to a legally married mother but still be illegitimate—when the father of the child is not the mother's husband.

As a child conceived and born in lawful wedlock normally is considered legitimate, then the question of whether a child born to a common law marriage is to be considered legitimate or illegitimate depends upon what legal status is given to common law marriages in Texas.

In Texas, a common law marriage is a real marriage which can be dissolved only by death, divorce, or annulment. The legal status of the man and the woman is that of husband and wife. Any children born of such common law marriage are legitimate and capable of inheriting. Since children born of a common law marriage are considered legitimate, the question then arises as to just what elements are necessary to constitute a common law marriage.

The parties to a common law marriage must have met the same personal requirements as the parties to a statutory marriage—that is, opposite sex and legal age, and must possess none of the legal disqualifications such as those with respect to race, kinship, existing marriage and the like. The parties must have agreed to a present marriage, and such agreement must have, in fact, been consummated by a living and cohabiting together as husband and wife. Just what acts by the parties will suffice to establish the necessary elements for a common law marriage have never been firmly stated by the courts, but it seems that the acid test would be uniform assertion to the public, by each party, that they are husband and wife—evidenced by such acts as listings in phone books, city directories, listing of utilities, and signing of papers.

As can be seen, the filling out of a birth certificate often can present the physician with legal questions as was shown in this case. The mere fact that the mother is unwed in a statutory sense does not absolutely prohibit the entering of the father's name upon the birth certificate, because if it should be established that a common law marriage existed, then the entering of the father's name upon the birth certificate would be proper. Of course, if such common law marriage cannot be established, the name of the father should not be entered upon the child's birth certificate.

—PHILIP R. OVERTON, LL.B., Austin.

EDUCATION

Postgraduate Courses

Endocrine Disease, Houston, July 20.—The University of Texas Postgraduate School of Medicine will offer a course in endocrine disease on July 20 at the M. D. Anderson Hospital in the Texas Medical Center in Houston. Tuition is $10 and 6 hours credit will be given. Those interested may write The University of Texas Postgraduate School of Medicine, Texas Medical Center, Houston.

Gynecology, Houston, August 5-28, September 2-25.—Courses in clinical gynecology and in gynecologic pathology will be held by the University of Texas Postgraduate School of Medicine each Tuesday and Thursday between August 5 and 28 and September 2 and 25, respectively, in Houston.

Athletic Injuries, Denver, August 25-27.—A postgraduate course on the prevention and management of athletic injuries will be offered August 25-27 by the Division of Orthopedic Surgery of the University of Colorado Medical Center. Lectures, panel discussions, and demonstrations will be presented as part of the course. Registration fee is $5 and tuition fee is $30. Further information may be obtained from the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

Dermatologic Histology, New York, September 8-12.—A complete review of both the normal histology of the skin and the essential histopathology of diseases of the skin will be given at the New York University-Bellevue Medical Center Post Graduate Medical School in the review in dermatologic histopathology. The class is limited to 20 persons and the tuition is $85.

Heart Disease, Austin, September 16-17.—"The Newer Advances in the Hypertensive Management of the Cardiac Patient" will be offered by the University of Texas Postgraduate School of Medicine at the City Health Auditorium in Austin, September 16-17.

Research Foundation Appointments

Texas doctors recently were named new directors of the Board of the Medical Research Foundation of Texas. They are Dr. Carlton B. Chapman, professor of medicine at Southwestern Medical School in Dallas; Dr. Michael E. DeBakey, professor of surgery at Baylor University College of Medicine in Houston; Dr. Robert A. Johnson, Houston; and Dr. Howard O. Smith, Marlin, President of the Texas Medical Association.

Dr. Carl A. Naul, professor of preventive medicine and public health at the University of Texas Medical Branch in Galveston, has been appointed chairman of the foundation's research grants committee. Other members named to the committee include Dr. Mavis P. Kelsey, professor of internal medicine at the University of Texas Postgraduate School of Medicine in Houston; Dr. Milford O. Rouse, Dallas; Dr. DeBakey; and Dr. Chapman.

Dr. George A. Constant of Victoria spoke at the initial meeting of the foundation's San Antonio advisory committee recently.

University of Texas Medical Branch

Members of the faculty of the University of Texas Medical Branch in Galveston, *Dr. Robert M. Moore,* professor of surgery, and *Dr. Harriet Felton,* professor of pediatrics, attended the meeting of the American Surgical Association, April 16-18, in New York.

Dr. Russell Blattner, chairman of the Department of Pediatrics at the Medical Branch, was one of the guest speakers for a course in postgraduate obstetrics and pediatrics in Regina, Saskatchewan, Canada.

A testimonial dinner honored *Dr. John G. Sinclair,* professor of histology and embryology at the Medical Branch, May 17 for his 30 years of service to the institution. He is retiring from active participation August 30, but will remain at the medical school in modified service in the Department of Anatomy.

A grant of $600,000 was presented by the Sealey and Smith Foundation of Galveston in May to the Medical Branch for rehabilitating and modernizing the out-patient department of the Medical Branch.

Work on the department renovation should start before the end of the year, according to officials. The foundation grant supplements an appropriation by the legislature of $1,228,823 for further and urgent remodeling needs at the Medical Branch, including the Galveston State Psychopathic Hospital, Rebecca Sealy Nurses' Residence, and other structures.

Southwestern Medical School

Dr. Ivan E. Cushing, Jr., professor at the University of Texas Southwestern Medical School, Dallas, will share in the $28,231 in grants which have been made to Texans for study of heart and blood vessel diseases by the American Heart Association.

The Southwestern Medical Foundation's annual grant to Southwestern Medical School, Dallas, has been increased from $88,700 for the past fiscal year to $97,000 for the 1958-1959 fiscal year. The increase is mostly for salary supplements to permit the medical school to develop and maintain an outstanding teaching staff, reports Karl Hoblitzelle, president of the foundation.

The following officers of the foundation were reelected: Mr. Hoblitzelle, president; George L. MacGregor and J. L. Latimer, vice-presidents; Harold B. Sanders, secretary and general counsel; and Fred F. Florence, treasurer, all of Dallas. Dr. Glenn D. Carlson of Dallas was elected to the board.

The foundation also has made a $50,000 grant to Southwestern Medical School for the activation at Parkland Memorial Hospital of a teaching and research clinic in the disease of alcoholism. The grant is for a 2 year program.

The University of Texas budget for the forthcoming school year includes $2,126,554 for the Southwestern Medical School in Dallas, an increase of 3.8 per cent over the current budget.

Baylor College of Medicine

Dr. Arthur Kirschbaum, chairman of the Department of Anatomy at Baylor University College of Medicine, Houston, died May 28 of a coronary occlusion. He also served as consultant of the M. D. Anderson Hospital and Tumor Institute and the Veterans Administration Hospital. He was graduated from the University of Minnesota Medical School in 1943. The author of more than 65 papers, he was nationally recognized for his work in cancer research.

Dr. Ellard Yow, professor of internal medicine at Baylor, was invited by Hahnemann Medical College, Philadelphia,

to serve as the Eberhard Foundation Visiting Professor in Medicine from May 6 to 10. He delivered the Student Institute Honor Lecture on "Microbiologic Ecology and Human Infections."

Dr. Stanley W. Olson, dean of Baylor, will visit clinics and hospitals around the world along with a team of three other physicians. The physicians, under the sponsorship of the Baptist World Alliance, left San Francisco on June 27 and will return to New York in late September.

Summer research fellowships have been awarded to 35 students of the medical school this year. The grants, totaling $20,300, were made by numerous sources.

AMEF Report

A report on contributions made to medical schools in the United States during 1957 has been released by the American Medical Education Foundation.

Direct physician contributions to Baylor University College of Medicine totaled $18,750.20. The University of Texas Medical Branch received $11,830.32. Figures for Southwestern Medical School, University of Texas, were not available. The University of Vermont College of Medicine headed the list of schools with a total of $226,752.50 received in contributions. The school reporting the smallest total was the West Virginia University School of Medicine, a 2 year basic science school, which reported $50 received.

Contributions received in Texas from physicians' contributions to medical education amounted to $90,827.56. This included $29,716.78 from AMEF and $61,110.78 from alumni sources. California, with a total of $226,752.50, reported the highest amount received. Idaho, with a total of $4,768.77, was the lowest.

Each medical school in the United States received $5,900 in undesignated grants from AMEF. Two year basic science schools were given $2,950. The AMEF grant plus contributions from donors boosted the totals of Baylor University College of Medicine to $9,337.91, the Medical Branch to $10,302.84, and Southwestern to $8,861.95. The highest schedule of grants was reported by California's College of Medical Evangelists, which received $51,299.71; the lowest was the University of Florida School of Medicine (a 2 year basic science school) which received $2,950.

Vocational Nursing Licenses

Newspapers throughout the state have been asked by the Board of Vocational Nurse Examiners to check advertising coming to them from schools of vocational or practical nursing, according to Dr. George Hilliard of Jacksonville, president of the board.

The board initiated this action after receiving numerous complaints by persons who enrolled in unapproved schools, sometimes offering correspondence courses, in the hopes of becoming licensed vocational nurses, only to find out later that the schools were not accredited and that they could not obtain a license.

Vocational nurse licenses are issued only after an applicant has completed 12 months of vocational nurse training at an accredited school. The minimum course requires 200 hours of classroom instruction and 1,200 hours of supervised clinical practice. Accreditation is given by the board.

MEDICAL MEETINGS

Occupational Health Conference

A Conference on Guiding Principles for an Occupational Health Program in a Hospital Employee Group was held in Austin, June 5-6, under the sponsorship of the Committee on Industrial Health of the Texas Medical Association. The purpose was to clarify pertinent points and to outline a program in which all interested organizations could make contributions.

Representatives from various organizations agreed to approach the problem by including information about it in their internal publications and by a mutual exchange of ideas. They also decided upon a conference for medical groups and other interested organizations. It was decided that representatives of all organizations would be invited to the September meeting of the Committee on Industrial Health to plan a format for the program and speakers.

Organizations represented were the Texas Medical Association, Texas State Department of Health, Texas Hospital Association, Private Clinics and Hospitals Association of Texas, State Board for Hospitals and Special Schools, Texas Industrial Medical Association, and Texas Industrial Nurses Association.

Obstetricians and Gynecologists to Meet

The District 7 meeting of the American College of Obstetricians and Gynecologists will be held in Jackson, Miss., September 12-13. The program, beginning with a fellowship tour on the evening of September 11, will include scientific papers, round tables, and movies. There also will be entertainment for the ladies.

Announcement of the meeting comes from Dr. C. G. Sutherland, Jackson, president of the Jackson Gynesis Society.

Congress of Physical Medicine and Rehabilitation

The American Congress of Physical Medicine and Rehabilitation will hold its thirty-sixth annual scientific and clinical session August 24-29 in Philadelphia. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Full information may be obtained by writing to the Executive Secretary, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2.

Israel Medical Assembly

The fourth World Assembly of the Israel Medical Association will be held in Tel Aviv, Jerusalem, and Haifa in Israel, August 12-24. Celebration of Israel's tenth anniversary, which coincides with the meeting, will supplement the normal conference activities. Information may be secured from the American Physician's Fellowship, 130 Beacon Street, Brookline, Mass.

Lectureship in San Angelo

The second annual Shannon Lectureship in Medicine will be held October 18 in San Angelo. Speakers chosen for the meeting are Dr. Jerome W. Conn, professor of medicine at the University of Michigan, and Dr. George W. Thorn, professor of medicine at Harvard University. The men will present a program in the field of endocrinology and metabolism.

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Palvite will produce Vitamin B-12 serum levels superior to those obtained with injections of 100 mcg. B-12. Increased use of oral B-12 therapy was seen as a possible result of studies reported at the third Vitamin B-12 symposium, held in New York City recently. Investigators told of increased absorption of the orally administered vitamin in the presence of intrinsic factor if it was given in a vehicle containing sorbitol. Palvite utilizes sorbitol as the vehicle.

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OF GENERAL INTEREST

Personals

Dr. J. R. Maxfield, Jr., Dallas, has been guest speaker at various meetings recently. Among those include the meeting of the Texas Association of Medical Record Librarians in Dallas, the A & M College of the Texas Chapter of the Society of the Sigma Xi in College Station, and the Medical Association of Georgia in Macon, Ga.

Dr. Homer R. Goehrs, Austin, is attending the annual meeting of the American Rheumatism Association in San Francisco, June 20 and 21. He will present a paper at the meeting on "Heart Lesions in Patients with Rheumatoid Arthritis."

Dr. Harry S. Lipscomb, Houston, is a recipient of a Smith, Kline and French Foundation grant for study of neuroendocrine mechanisms related to aldosterone secretion. These studies will be undertaken in collaboration with *Dr. George W. Clayton* of Houston.

Dr. Mary A. M. Henry, San Antonio, was a participant at a panel on "The Physician in the Role of Advisor" at the meeting of the American Medical Women's Association in San Francisco, June 19-22.

Dr. Andrew Tomb of Victoria gave two papers at the Montana Academy of General Practice in Billings, Mont., June 20-21.

Dr. Marie Gordon, San Antonio, was installed recently as president of the Girls Council, sponsors of Aganier Hall, a home for homeless girls.

Dr. William P. Devereux, Dallas, was named vice-chairman of District VII of the American College of Obstetricians and Gynecologists at its annual meeting, April 21-23, in Los Angeles.

Dr. Henry C. Paine of LaGrange has been assigned to the Ninetieth Infantry as division surgeon. He is a lieutenant colonel in the Army Reserve.

Richard C. Foster, formerly of Uniontown, Penn., has been appointed assistant director of hospitals in charge of professional services of the University of Texas Medical Branch in Galveston.

Mrs. Robert W. Kimbro of Cleburne, wife of the chairman of the Board of Trustees of the Texas Medical Association, died July 1. The former Miss Alice Ann Ragsdale, Mrs. Kimbro is survived by her husband, Dr. Kimbro, and two children, Penny and Robert W., Jr.

Effective Diuretic Reported

A new drug, chlorothiazide (Diuril), recently has been called the most effective agent available for combating excessive fluid retention by the body. Four articles in the January 11 issue of the *Journal of the American Medical Association* describe the various uses of the drug.

Because of the drug's lack of harmful side effects and its economy and ease of administration by mouth, it is probably the most effective diuretic now available, say Dr. Ralph V. Ford and his associates in Houston.

A group of New York doctors found the drug to work against fluid retention caused by heart failure, cirrhosis of the liver, and nephrosis when all other measures had failed. Value in hypertension and in toxemia of pregnancy is considered in articles by two groups from Washington.

Over half of all allergy sufferers give a history of allergic diseases in other members of the family, according to "Patterns of Disease," Parke, Davis and Company publication. Transmission of the allergic tendency seems to occur twice as frequently through the woman as through the man.

Texas Hospitals Foundation

The Texas Hospitals and Special Schools Foundation has been established by members of the Board for Texas State Hospitals and Special Schools primarily for the benefit of institutions which are under the jurisdiction of the board. Board members, who serve as trustees of the foundation, found that despite the increase in operating appropriations by the Fifty-Fifth Legislature, money to provide training and upgrading of personnel in key medical areas was limited.

Funds in excess of $10,000 have been deposited in the trust by individuals and organizations. One $3,000 contribution was earmarked for consultants, workshops, seminars, or scholarships and this particular sum cannot be applied to salary supplements.

Contributions are welcomed and should be made payable to the foundation and mailed to the American National Bank, Austin.

Booklets on Heart Disease

A new 16 page statistical handbook, published in March by the American Heart Association in cooperation with the National Heart Institute and the Heart Disease Control Program, is available to those interested. It answers some of the most common questions people ask about cardiovascular disease.

The publication is arranged in a series of color charts, each accompanied by a short interpretive text, suitable for laymen and professional people alike. Single copies may be obtained without cost by writing the National Heart Institute, Public Health Service, Bethesda 14, Md., or the American Heart Association, 44 East 23rd Street, New York 10. Additional copies may be purchased from the American Heart Association at 15 cents per copy, $15 per 100 copies.

Test for Diabetes

A new test which may be helpful in diagnosis of mild diabetes has been reported by the Veterans Administration hospital in Dallas. Sodium tolbutamide is injected in the patient's vein, and the response of the blood sugar level is analyzed 20 and 30 minutes later. Nondiabetics showed a rapid decline in blood sugar level whereas the level in diabetic patients falls much more slowly. Reports were based on tests made on 100 nondiabetics and 75 diabetics by Drs. Roger H. Unger and Leonard L. Madison, who are on the faculty of Southwestern Medical School of the University of Texas as well as the hospital staff.

Staphylococcus Infections Subject of Bulletin

Measures to aid in reducing the current worldwide problem of infections in hospitals caused by antibiotic-resistant staphylococci are recommended by the American Hospital Association in a bulletin on "Prevention and Control of Staphylococcus Infections in Hospitals."

The publication was mailed by the Association to the more than 7,000 hospitals in the United States and Canada. The bulletin suggests that all hospitals establish committees on infections to devote particular attention to infections which are acquired in hospitals so that they may be reduced to the lowest possible minimum.

Husband-Wife Doctor Teams Find Solutions to Problems

Husband and wives in active practice enjoy their work although they have some problems, according to replies received from representative couples suggested by various county medical societies which have one or more husband and wife doctor teams.

The physician teams have much in common, for most of them met while in medical school, married immediately after medical school or while serving their internships, and belong to the same professional societies. Several of the couples sat next to one another in classes as their last names began with the same letter, and others were lab partners or were in the same classes.

An inquiry sent to county medical societies revealed at least 37 husband-wife doctor teams in the state. Some of the wives, however, work part time or are in semiretirement. According to the questionnaire, the largest concentration of these couples is in Nueces County, where the following couples are in practice: Drs. Mose H. and Alva L. Blaine; Drs. Hans E. and Katheryn (Heaney) Heymann; Drs. John K. and Bernice Kohlhaas; Drs. Gregory M. and Mary M. McCaskey; Drs. Robert H. and Elizabeth C. Thomason; Drs. Jack E. and Bette Upshaw; and Drs. Richard R. and Helen Woods, all of Corpus Christi.

Dallas County Society also reported a large number of physician teams. They are Drs. Donald G. and Dorothy (Finley) Brooking; Drs. Russell and Lois Jordan; Drs. Floyd A. and Gladys (Fashena) Norman; Drs. James R. and Roycerene Phillips; and Drs. Thomas and Robbie Jo Shires, all of Dallas. Among husband-wife teams in Tarrant County are Drs. C. Harold and Grace Beasley; Drs. Robert E. and Martha J. Chapman; Drs. Albert M. and Diane Goggans; and Drs. Edgar L. and Minnie Lancaster, all of Fort Worth.

Travis County Society also reported several couples in the medical profession. They are Drs. Carey and Georgia Legett; Drs. Thomas M. and Gretchen Runge; Drs. Margaret and Miles E. Sedberry; Drs. Albert A. and Alice Marie (Cornell) Tisdale; Drs. Harriss and Dola (Booth) Williams, all of Austin. Several county societies said that they had one or two pairs of husband and wife physician teams. These include McLennan County with Drs. Carl and Lillian Friedman, Waco; Comal County Society, Drs. Fred and Bertha Frueholz, New Braunfels; Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Society, Drs. Cecil A. and Rose Robinson, Kermit; Denton County Society, Drs. J. David and Bobby (Short) Thomas, Denton; Andrews-Ector-Midland Counties Society, Drs. Lynn and Jackie Hunt and Drs. Robert and Caroline Lewis, both of Odessa; LaSalle-Frio-Dimmit Counties Society, Drs. John and Marion Primomo, Dilley; and Webb-Zapata-Jim Hogg Counties Medical Society, Drs. Leonides G. and Margaret Cigarroa, Laredo.

The biggest problem most such couples face is that of finding enough time to spend with their children. Drs. Leonides G. and Margaret "Peggy" Cigarroa of Laredo, whose four children range from 6 years to 9 months, agree this is by far their biggest difficulty. Dr. Leonides says, however, that his wife squeezes in time to make the children's party dresses, Halloween costumes, and Christmas decorations. He is amazed at the energy she shows while playing with the children at the end of a long day.

The two physicians often duplicate gifts. When a present is needed for their children or a friend, each may run out to buy it in a spare moment thinking that the other will not have time. They also each occasionally accept invitations to parties at the same time but at different places. Usually they take two cars to parties or movies, and sometimes people think they are mad at each other because they arrive and depart separately.

Many times week-end trips to the seashore are canceled because Dr. Leonides has a tough surgery schedule or Dr. Peggy, a general practitioner, has to deliver a baby. They frequently use each other as consultants, and Dr. Peggy sometimes assists her husband with surgery. Medicine is a habit in the Cigarroa family; Dr. Leonides' father and brother practice in Laredo and his sister is a pharmacist there.

Drs. Russell and Lois Jordan of Dallas solved their problems by Dr. Lois working only part time so that she can spend more hours with their children, aged 7, 5, and 3. She looks forward to returning to full time work when the children are older. The couple has been practicing for 12 years as partners, specializing in obstetrics and gynecology. They both received their medical education at Johns Hopkins Hospital.

Drs. John and Marion Primomo's biggest problem is trying to find someone to take over the practice in their 14-bed hospital at Dilley, which they own and operate, while they go on vacations with their four children ranging in age from 9 to 2 years. The couple are the only physicians in the community. They met as classmates at Loyola Medical School in Chicago and married after graduation.

Drs. Fred and Bertha Frueholz, New Braunfels, who have been in general practice for 40 years, agree that they had the most trouble in obtaining competent help when their two children were young. The problem was solved partially by a relative who came to live with them for a while but later went back to Germany. Dr. Bertha then took her son with her on house calls so she would know where he was. The son, Dr. Frederick Jr., now shares a clinic with his mother and father. Both of the senior Frueholzes are interested in photography. They married while they were interning at the City and County Hospital in Stuttgart, Germany. Both went to medical school at the University of Tuebingen in Germany.

Being a husband and wife physician team necessitates the owning of two cars, according to Drs. Robert and Elizabeth Thomason of Corpus Christi, who have two children ages 19 and 10. Another "must" in their opinion is full time domestic help. Dr. Robert is an internist in Corpus Christi and Dr. Elizabeth is county physician. They have separate offices, but Dr. Elizabeth uses her husband's office whenever she needs it. They married while interning at the Baltimore City Hospital in Baltimore.

Drs. Carey and Georgia Legett of Austin have scheduled their work so that they can be with their children more. Dr. Georgia, who specializes in obstetrics and gynecology and Dr. Carey, who is an ophthalmologist, have part of every afternoon free during the summer to go swimming with their children, who are ages 9, 7, 5, and 3. They also take their children to Sunday school and church. Many times, however, her work interferes with planned activities with her family. In such cases, her children know she must go when needed. To help with the domestic duties, the Legetts have a maid during the day although Dr. Georgia usually cooks breakfast and supper. Until this year, a University of Texas student lived with them to help take care of the children.

"Learning how to relax as an individual is important when both husband and wife are physicians," said Dr. Georgia. Before leaving the office, she writes down all information which she needs to remember and then closes the books both mentally and physically. She thinks it would be hard being a nonmedical wife, for the wife would not understand the emotional tension through which a doctor

goes. She believes that they have considerably fewer problems since they are in different fields of practice. They always go to each other's specialty meeting.

Most of the couples probably have the same feeling as one doctor who expressed himself about him and his wife: "We both know that our practices come before any enjoyment, so whenever we are called, we go. It is my firm conviction that respect for each other's dedication to the profession is the greatest tie in maintaining an understanding and in preserving a great happiness in a 'doctor-doctor' husband-wife team."

TB Topics: Pregnancy and Tuberculosis

Since the advent of good antituberculous drugs, the concept and methods of handling the pregnant tuberculous patient have changed considerably. Formerly, abortion in a patient with active tuberculosis was the rule, and now whenever abortion is considered, it is for gynecological or other reasons unrelated to the tuberculosis. The additional work and poor hours which a new mother will have to experience the first year after she delivers are important considerations in her treatment.

It is accepted obstetric procedure to obtain routine chest roentgenograms on the patient. The radiation hazard is minimal. In the pregnant case there is need for haste in arriving at the diagnosis of activity so that treatment can be instituted. There is more than ample evidence to show that the recommended dosages of streptomycin isoniazid (INH), and para-aminosalioylic acid (PAS) have no deleterious effect on the infant.

It is recommended that patients with activity be placed on drug therapy, that is, streptomycin (dihydrostreptomycin or a mixture), INH, and PAS. The usual dosage schedule is recommended: streptomycin, 1 Gm. biweekly; INH, 100 mg. three times a day; and PAS, 12-16 Gm. daily in divided doses. It is recommended that something other than the sodium salt of PAS be used for pregnant women. The treatment should be instituted as soon as possible and maintained for a minimum of 18 to 24 months, depending on the course of the illness.

It is advisable that the patient be isolated when hospitalized for delivery. It is important to make the labor as brief and comfortable as possible with perhaps a little more liberal attitude than usual concerning cesarean section, middle forceps, and so forth.

The infant of a mother with active tuberculosis should be separated from her and not allowed in contact with her until her disease is in such shape to make such contact completely safe.

It is of much importance that considerable attention be paid to the tuberculosis the first few months postpartum. It is during this time that the stable cases will reactivate or that there will be an exacerbation of those with slight activity.

The whole problem of pregnancy and tuberculosis is analogous to the answer which a multiparous Tennessee mountain woman gave when she said, "It ain't having 'em that's hard—it's taking care of 'em."

—Committee on Tuberculosis,
Texas Medical Association.

Correction: Texas Diabetes Association

Dr. B. C. Wallace of Waxahachie is the recently elected vice-president of the Texas Diabetes Association instead of Dr. Frank Wallace of Arlington, as was reported in the June issue of the *Texas State Journal of Medicine* on page 364.

Medical Progress Reason Women Live Longer Than Men

"Each year over 200,000 more men than women die in this country. . . . Already there are 7,700,000 widows in our population, and the number is expected to rise sharply in the years ahead," according to the *Progress in Health Services*, a bulletin published by the Health Information Foundation.

The bulletin pointed out that the imbalance between male and female death rates is partly the result of medical progress. In countries in which standards of living and medical care are low, there has been an excess female mortality until recently, partly because of the hazards attending childbirth. This cause of death, the Foundation said, no longer represents a significant aspect of the problem.

In the past half century, the degenerative diseases have replaced communicable illnesses as leading causes of death, and degenerative diseases, as a rule, are more of a threat to men than to women. Accidents are another major cause of excess male deaths, according to the bulletin.

Speeding Ambulances

In 2,500 consecutive ambulance runs, there was only 1 case in which a moderate delay in transportation could have resulted in death, according to a report made by Dr. George J. Curry and Dr. Sydney N. Lyttle of Flint, Mich.

An ambulance averaging 30 miles per hour would require 10 minutes to travel 5 miles. To save 5 minutes, 60 miles per hour would be necessary. In the cases studied, this time interval would not have influenced the course of a single injury, said the physicians.

It was recommended by Dr. Curry and Dr. Lyttle that ambulances should observe the local speed laws, retain the use of their sirens, and have the right of way in traffic.

Visits to Physicians' Survey

Persons visited their physicians during the months of July, August, and September of 1957 at the rate of almost five times a year, according to the first of a series of reports made by the United States National Health Survey.

The data gathered through household interviews showed that the survey was made at a time of year when people are normally least likely to call the doctor. The report notes that last year respiratory diseases were probably at above average levels. Nine out of 10 of the visits were in the physician's offices.

Persons living on farms used the physicians' services during the quarter at a rate of 3.6 visits a year, compared with 4.5 for the rural nonfarm population and 5.1 for the urban population.

Infectious Hepatitis Still Problem

Reported cases of infectious hepatitis have been decreasing over the past 3 years, but still remain a serious public health problem, report statisticians of the Metropolitan Life Insurance Company.

From an all time high of more than 50,000 reported cases in 1954, the number dropped to an estimated 15,000 cases in 1957. Statisticians say that in order to bring this disease under effective control, much additional information regarding its diagnosis, prevention, and treatment will be required.

Medical TV Wins Recognition

"MD International" and "Monganga," two late *March of Medicine* television reports on the work of American doctors, have been selected for presentation at the Brussels World Fair. The films were produced and sponsored by Smith Kline & French Laboratories.

"Grand Rounds," the Upjohn Company's closed circuit medical programs, won first award for a network educational series in a national competition sponsored by the Ohio State University.

Tranquilizing Drugs Evaluated

Four tranquilizing drugs are being evaluated for use in treatment of mental illness by a Veterans Administration study at 35 hospitals including those in Houston and Waco. Drugs to be used are the compounds proclorperazine, trifluprazine, perphenazine, and mepazine.

The 12 week project will involve 800 veterans who are victims of schizophrenia and who have recently been admitted to the participating hospitals. Chlorpromazine also will be administered in the study, since comparison of its effects will aid in evaluating effects of the other drugs.

Immunizer Against Ivy Poisoning

Poison ivy victims can prevent the serious painful effects of exposure to toxic weed by taking a few drops of immunizer before breakfast, Dr. Elmer R. Gross, a dermatologist of Wilmington, Del., reports in the March issue of *Industrial Medicine and Surgery.*

Dr. Gross made a 5 year study of 455 adults and children who were given Oral-Ivy. All had a previous history of sensitivity to poison ivy. After taking the immunizer, 76.9 per cent of the subjects were either free of ivy dermatitis or experienced milder attacks.

Baboons Imported to San Antonio

Twenty baboons were transported to Texas from Africa in March for experiments in connection with the disease atherosclerosis at the Southwest Foundation for Research and Education in San Antonio. In June, scientists hoped to import 500 more.

The expansion of the research program has been made possible by the pledge of $50,000 made by Houston oilman, Douglas Marshall, chairman of the Texas Heart Research Foundation. The choice of baboons over such animals as mice, guinea pigs, and rabbits was made because the baboon is the only animal other than man that gets the disease.

Obstetrics and Gynecology Diplomates

At the May examinations of the American Board of Obstetrics and Gynecology, the following Texas physicians were certified as diplomates: Dr. Robert N. Arnold, Lubbock; Dr. Charles H. Bruce, Dallas; Dr. John K. Cox, Houston; Dr. Stewart A. Fish, Dallas; Dr. James E. Gleichert, Dallas; Dr. William R. Kerr, Houston; Dr. Gilbert Landis, El Paso; Dr. Joseph A. Lucci, Houston; Dr. Henry C. McGrede, Jr., Longview; Dr. Malcolm M. MacRae, Waco; Dr. Jack Moore, Houston; and Dr. Raymond B. Wait, San Antonio.

MEMORIAL LIBRARY

Roman Fresco—What Is Its Meaning?

The accompanying picture is a reproduction of a fresco found recently in a newly discovered catacomb on the outskirts of Rome, Italy. On April 5, 1956, Father Antonio Ferua, S. J., secretary of the Pontifical Commission of Sacred Archaeology, announced the discovery of the catacomb beneath the modern Via Dino Compagni. This street occupies a portion of the old Via Latina, which branched to the east from the Via Appia beyond the Porta Capena and joined it again at Casilinum. The catacomb was a private place of burial, probably belonging to one family or group of families, and so is not recorded in early liturgical documents which list the more famous catacombs where martyrs were interred. In the second level of the catacomb are more than 50 frescoes which, on the basis of architectural style and decorations, are assigned to the fourth century A. D. The frescoes represent scenes from the Old and New Testament, from mythology, and from the scene represented here. In time to come, this picture undoubtedly will take an important position in the history of art and medicine.

What is this scene and what does it represent? According to the information released by the commission, this represents a Roman surgeon during an operation as colleagues look on. We have no other information as to why they came to this conclusion, but it is probably not true. Dr. Curt Prodkauer, curator of the Charles Land Museum at the Columbia-Presbyterian Medical Center, New York, thinks this represents a dissection for the purpose of teaching anatomy and not a surgical operation. Dr. John F. Fulton, Sterling Professor of the History of Medicine at the Yale University Medical School, agrees in general with Dr. Proskauer's interpretation of the scene. Regardless of the interpretation, this is a very interesting picture. I personally feel that this is a dissection scene. In ancient Rome it was not possible to open the chest or abdomen to the extent that the body in the fresco has been opened without killing the patient. Mario Tabanelli, however, in his "Chirurgia nell' antica Roma" (Torino, Edizioni Minerva Medica, 1956) interprets this not as a dissection scene but as a clinical lesson on the living patient, and cites in support from Aurelius Cornelius Celsus' "De Re Medicina" (circa 40 A. D.), Liber I, "The abdomen may be laid open, it is true, even while the man is breathing; but as soon as the knife has approached the praecordia and diaphragm the man immediately expires."

It will be interesting to see how the catacomb, which consists of a cavern 158 by 89 feet, was dated to the fourth century A. D.; however, that will have to be accepted until we have further information from the commission.

Should this prove to be a dissection scene, it will predate the first known anatomical dissection by about 900 years.

The Egyptians were skilled embalmers and surgeons, but they did not use the human body for teaching demonstrations. The Greeks dissected animals but not humans. Claudius Galen of Pergamos dissected swine. The first known dissection of the human body occurred in Bologne during epidemics of the later thirteenth century, notably in the year 1286 (A. Corradi, "Annali deile epidemis in Italia della prima memorie fini al 1850," under the year 1286).

Undoubtedly, earlier dissections occurred but only as clandestine affairs which had no sanction by authorities.

Dr. Charles Donald O'Malley, professor of history, Stanford University, is much more skeptical. He says, "What is such a scene doing in a Roman Catacomb? Does one of the figures actually have a pointer in his hand and is it therefore an ostensor? We have previously thought the ostensor did not come into being until the medieval or early renaissance period when the classical writings had gained

Recently discovered fresco in a catacomb at Rome, Italy, depicting, perhaps, a dissection. (Photograph sent to the author by Dr. Ester Balestra, Rome, Italy.)

such authority that the professor was required to read while some one else pointed out the various aspects of the anatomy. Then there is the question of the middle figure, much larger than any of the others. Is he the teacher? If so why is he not depicted as participating in the anatomy? Why is the body on the ground rather than on a table which would be far more convenient? Furthermore, if the group represents teacher and students, they are the most inattentive on record since they are all looking anywhere but at the cadaver! Could this be that of a scene representing Christ and the twelve Apostles? It is possible to make a count of twelve. Is the body that of some dead person who is about to be brought back to life? Is the black spot on the body a wound or the result of an autopsy?"

In any event this is an interesting picture to observe and think about. Only time will place a proper evaluation upon it. What do you think?

—WILLIAM M. CRAWFORD, M.D., Fort Worth.

Gifts to the Library

Dr. Paul W. Barker, Austin, 520 journals.
Dr. Sam N. Key, Jr., Austin, 9 journals, 1 book.
Dr. Robert W. Loveless, Bastrop, 47 journals, 3 books.
Dr. Robert G. McCorkle, Jr., Austin, 87 journals, 38 books.
Dr. W. E. Morris, Corpus Christi, 113 bound journals.
Philip R. Overton, Austin, 15 journals.
Dr. A. D. Pattillo, Austin, 34 journals.
Dr. Nelson L. Schiller, Austin, 36 journals, 2 books, reprints.
Dr. Oliver W. Suehs, Austin, 43 journals.
Dr. Milton Turner, Austin, 112 journals.
Dr. Odon F. von Werssowetz, Gonzales, 1 journal.
Mrs. R. N. Winship, Jr., Houston, 101 books.
William G. Wolfe, Austin, 1 book.
Dr. David R. Womack, Austin, 60 journals, reprints.

★ Motion Pictures

Back Into the Sun

16 mm., black and white, sound, 27 min., 1957.

Produced at the day hospital of the Allan Memorial Institute of Psychiatry in Montreal, this film documents the role of the day hospital, a relatively new approach to the treatment of the mentally ill. Using the story of a young married woman, the film shows the range of treatments, constructive activities, and relationships she experiences during the hours she spends at the hospital.

David—The Profile of a Problem Drinker

16 mm., black and white, sound, 27 min., 1957.

Depressed after one of his extended drinking sprees, David and his wife accept a friend's advice to consult a doctor. Tracing his "disease" to its beginnings, the picture points out how, as a shy, young man, David overcame his timidity by drinking. Frustrations in his job and other circumstances strengthen the habit. The doctor points out that the case is not hopeless, but, like any disease, will require long effort and patience.

The H-Bomb

16 mm., black and white, sound, 22 min., 1956.

The results of an H-bomb explosion in England are examined from the point of view of civil defense. Animated drawings and live photography depict the effects of heat, radiation, and blast of an H-bomb as compared with an atomic bomb, and the civil defense measures that would be necessary. The film concludes with a summary of the contents.

Vaginal Hysterectomy with Repair of Prolapse Demonstrating Heaney Technique

16 mm., color, sound, 17 min., 1957.

In this film, a vaginal hysterectomy demonstrating the Heaney technique is performed on a patient who has a third degree prolapse. All the steps used in doing a vaginal hysterectomy are indicated. The cystocele and urethrocele are repaired, and a posterior colpoperineorrhaphy is performed. This film will be of interest to specialists in training and to general practitioners.

★ Books

Books Newly Acquired

AMA Bureau of Health Education: *National Conference on Physicians and Schools, 6th Report,* Chicago, 1957.

Charny, Charles W., and Wolgin, William: *Cryptorchism,* New York, Hoeber-Harper, 1957.

Fleming, Jack W.: *Primer on Common Functional Disorders,* Boston, Little, Brown and Co., 1958.

Gofman, John W.; Nichols, Alex V.; and Dobbin, E. V.: *Dietary Prevention of Heart Disease,* New York, G. P. Putnam's Sons, 1958.

International Society of Hematology, Proceedings of the 6th Congress, New York, Grune and Stratton, 1958.

Markell, Edward K., and Voge, Marietta: *Diagnostic Medical Parasitology,* Philadelphia, W. B. Saunders, 1958.

Marshall, Otis: *Memoirs of a G. P.,* New York, Vantage Press, 1958.

Martin, Gustav J.: *Clinical Enzymology,* Boston, Little, Brown and Co., 1958.

Patton, Edwin F.: *Pediatric Index,* St. Louis, C. V. Mosby, 1958.

Rosen, George: *History of Public Health,* New York, M. D. Publications, 1958.

Wolfe, William G., and Reid, L. Leon: *Survey of Cerebral Palsy in Texas,* Austin, 1958.

World Health Organization, *International Classification of Diseases 1955 Revision,* 2 vol., Geneva, WHO, 1957.

Year Book of General Surgery 1957-1958, Chicago, Year Book Publishers, 1958.

Year Book of Neurology, Psychiatry, and Neurosurgery 1957-1958, Chicago, Year Book Publishers, 1958.

Year Book of Orthopedics and Traumatic Surgery 1957-1958, Chicago, Year Book Publishers, 1958.

Book Notes

Hormones in Blood

Ciba Foundation Colloquia on Endocrinology, vol. 2. Edited by G. E. W. WOLSTENHOLME, M.B., B.Ch. and ELAINE C. P. MILLAR, A.H.-W.C., A.R.I.C. 74 illustrations. 416 pages. $9. Boston, Little, Brown and Company, 1957.

This volume contains the proceedings of the forty-third small international conference held at the Ciba Foundation since 1950. It was the seventeenth conference on an endocrinological subject. The papers presented in this volume center around two major themes—how hormones are transported in the blood and how hormone levels in the blood are measured. The proceedings are issued with a minimum of editing to pass on the information and speculations to a wider audience.

Principles of Microbiology

CHARLES F. CARTER, M.D., Director, Carter's Clinical Laboratory, Dallas; ALICE LORRAINE SMITH, M.D., Associate Professor of Pathology, Baylor University College of Medicine, Dallas. ed. 3. 188 illustrations. 665 pages. $5. St. Louis, C. V. Mosby Co., 1957.

In the third edition of this volume the authors have held to the purpose stated in the first edition, "to add to the existing knowledge of microbes." With this in mind they have brought the existing material up to date, omitting ideas which have been disproved or which have become no longer of value. Chapters have been rearranged in more logical order, and new antibiotics, adenoviruses, and Salk vaccine added as subjects. Attempts to use the suggestions from teachers throughout the country have been made in this new edition, and changes have been made to render the book of greater usefulness as a teaching text.

Cortisone Therapy; Mainly Applied To the Rheumatic Diseases

J. H. GLYN, M.D., D. Phys. Med., Consultant in Physical Medicine to the Prince of Wales and Tottenham Group of Hospitals. 162 pages. $10. New York, Philosophical Library, Inc., 1957.

The Peter T. Bohan Memorial Lectures on Medicine

First Series. 128 pages. $3. Lawrence, University of Kansas Press, 1957.

Clinical and Immunologic Aspects of Fungous Diseases

J. WALTER WILSON, M.D., Los Angeles, Clinical Professor of Medicine, Dermatology, University of Southern California; Director, American Board of Dermatology. 280 pages. $6.75. Springfield, Ill., Charles C Thomas, 1957.

As the name implies, this book presents in some detail the clinical and immunological aspects of fungous diseases and is not intended to compete with more general textbooks of medical mycology. A casual observation of the title, together with the fact that the author and I are dermatologists, might lead one to believe that this book would be of interest primarily to this specialty. But it must be pointed out that approximately five-sixths of the text deals with the so-called deep fungi which can involve practically any organ system. Thus, this information is pertinent to the general practitioner as well as to many different specialists in both the clinical and basic science fields.

Considerable space is given to coccidioidomycosis, and the author points out that the study of this disease is useful as a guide in the study of infectious diseases in general. The text is stimulating and offers many suggested approaches for the needed research in medical mycology. Interestingly enough, mycology is cited as the oldest of microbial sciences. As early as 1841, David Gruby proved that a fungus could cause human disease by successfully completing experiments which, 40 years later, became known famously as "Koch's postulates" in relationship to tuberculosis.

Pertinent references are listed by disease in the bibliography.

—Marvin E. Chernosky, M.D., Houston.

Counseling in Medical Genetics

SHELDON C. REED, Director, Dight Institute for Human Genetics, University of Minnesota. 268 pages. Philadelphia, W. B. Saunders Co., 1955.

Most physicians are called upon to give genetic counseling from time to time. The patient expects answers regarding heredity in his family to be of the same high quality as the surgical or medical counseling which he receives. The purpose of this book is to help answer these questions. Only problems which have occurred most often in the Dight Institute for Human Genetics are covered. Only traits which appear with a frequency of better than 1 in 1,000 births are considered.

This book should be of considerable assistance to the family physician who must do counseling at the "grass-roots" level.

Pediatric Profiles

BORDEN S. VEEDER, Ed. Reprinted from the Journal of Pediatrics, November, 1954-November, 1957. 267 pages. St. Louis, C. V. Mosby Co., 1957.

Current Therapy, 1958: Latest Approved Methods of Treatment For the Practicing Physician

HOWARD F. CONN, M.D., Ed. 827 pages. $12. Philadelphia, W. B. Saunders Co., 1958.

Principles of Artificial Respiration

16 mm., sound, color, 27 minutes, 1957.

This picture shows the application of artificial respiration by a variety of techniques in various situations, particularly industrial accidents and hospital conditions.

ORGANIZATION SECTION

★ American Medical Association

AMA House of Delegates Takes Favorable Action On Three Texas Resolutions

Policies advocated by Texas delegates on social security coverage for physicians, Forand legislation, and Jenkins-Keogh type bills were adopted by the American Medical Association's House of Delegates at its June 23-27 meetings in San Francisco.

Only one resolution submitted by Texas delegates failed to gain support from the AMA's top policy-making body. Texas delegates presented four resolutions which had been adopted by the Texas Medical Association's House of Delegates at the Houston meeting in April.

While faring extremely well on questions of AMA policy, Texas delegates barely missed in their bid to elect Dr. Milford O. Rouse of Dallas as Vice-Speaker of the AMA House of Delegates. The post went to Dr. Norman Welch of Boston by a close 97-93 vote after Texas delegates had waged a spirited campaign.

The House of Delegates considered five resolutions pertaining to social security coverage for physicians, and rejected four of them while adopting the position advocated by Texas physicians. The action reiterated the present AMA policy, which is unequivocally opposed to compulsory inclusion of self-employed physicians in the social security system. The House turned down resolutions from New York and Connecticut calling for a nationwide referendum of AMA members on this issue and for participation in social security by physicians in individual states.

Acting favorably on another Texas resolution, the House of Delegates reaffirmed its strong endorsement of the Jenkins-Keogh plans, and urged prompt, favorable consideration of this legislation by the present Congress. The Jenkins-Keogh type plans would permit the 10,000,000 self-employed in this country to establish their own retirement programs, with favorable tax deferments until these funds are received in later life.

Favorable action also was taken on a Texas resolution which asked the AMA to oppose, emphatically and without reservation, the enactment of the Forand bill and legislation similar in philosophy. The Forand bill (H.R. 9467) provides a government financed program of free hospitalization, surgery, drugs, and nursing home care through social security.

The AMA House of Delegates did not support, however, the policy advocated by Texas delegates on Medicare. Earlier this year, the House of Delegates of the Texas Medical Association went on record in favor of repeal, modification, or amendment of the Medicare law (Public Law 569) in order to provide medical care for the dependents of personnel in the uniformed services through programs underwritten by voluntary prepayment plans or by pay increases adequate to enable military personnel to purchase voluntary prepaid health insurance.

The AMA House of Delegates rejected that resolution after a reference committee pointed out that the Medicare law contains a variety of methods of financing health care costs. The reference committee voiced the opinion that the objectives of the Texas resolution could be accomplished through modification of present implementing directives, and it stated that new legislation was not needed.

Acting on the recommendation of the reference committee, the House of Delegates also reiterated a previously adopted AMA policy which stipulates that ". . . the decision as to type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination."

Dr. Troy A. Shafer, Harlingen, served as chairman of the House's Reference Committee on Military and Veterans Affairs. All recommendations presented by Dr. Shafer were adopted by the House. Dr. Joseph B. Copeland, San Antonio, served as a member of the Reference Committee on Reports of the Board of Trustees and Secretary. Other Texas delegates who participated were Dr. Rouse; Dr. G. W. Cleveland, Austin; Dr. L. C. Heare, Port Arthur; Dr. T. C. Terrell, Fort Worth; and Dr. James H. Wooten, Columbus. Four alternate delegates, Dr. Ridings E. Lee, Dallas; Dr. John L. Otto, Galveston; Dr. James W. Rainer, Odessa; and Dr. J. C. Terrell, Stephenville, took an active role in deliberation and activities. Dr. Charles T. Stone, Galveston, served as the delegate from the AMA Section on Internal Medicine.

Nearly 500 AMA delegates, Texas physicians, their wives, and their friends visited the Texas hospitality suite at the Sheraton-Palace Hotel throughout the meeting. A Texas Jigger was given to each guest.

A participant in the Medical Society Executives Conference, held immediately preceding the AMA session, was C. Lincoln Williston, Austin, Executive Secretary of the Texas Medical Association, who played a part in a television skit entitled "The Medical Organization Man."

Orr Named President-Elect

Registration at the AMA session reached more than 37,500, including more than 13,000 physicians. Installing Dr. Gunnar Gundersen of La Crosse, Wis., as President, the organization named Dr. Louis M. Orr, Orlando, Fla., as President-Elect and voted a distinguished service award to Dr. Frank H. Krusen, professor of physical medicine and rehabilitation at Mayo Foundation, Rochester, Minn.

In addition to the items with special Texas import, the House of Delegates dealt with a variety of topics including relations between medicine and the United Mine Workers of America, voluntary health organizations, hospitalization of veterans, the AMA legislative system, hypnosis, over-the-counter medication, and an interprofessional code for physicians and lawyers.

Despite the opinion of the Board of Trustees and agreement of a reference committee that two resolutions adopted by the House of Delegates last December should not be implemented until a final report of the Commission on Medical Care Plans is received, the House adopted a floor amendment calling for immediate action. One resolution would institute a broad educational program to inform the general public, including beneficiaries of the UMWA welfare and retirement fund, "concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the 'Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement

Fund'" adopted by the House in June, 1957. The other resolution called for an AMA committee to engage in conferences with third parties to develop general principles and policies which may be applied to their relationships with members of the medical profession.

The House adopted a statement relating to problems that have arisen in relation to raising and distributing funds since development of the concept of united community effort. It reiterated its approval of the principal voluntary health agencies; indicated that they should be free to conduct their own programs of research, public and professional education, and fund raising; requested the American Medical Research Foundation to take no action that would endanger the constructive activities of the national voluntary health agencies, and urged the Board of Trustees to continue its study of the problems.

Congressional action to restrict hospitalization of veterans at Veterans Administration hospitals to those with service-connected disabilities was urged. The AMA was asked to suggest to dean's committees that they restrict their activities to Veterans Administration hospitals admitting only patients with service-connected disabilities.

The Board of Trustees was requested to make an immediate survey and reevaluation of the functions and effectiveness of the AMA's legislative system, including the Washington office, with the idea of achieving effective public and government relations. The Trustees were asked to implement any changes or additions found to be desirable.

A Council on Mental Health report on medical use of hypnosis was approved by the House of Delegates, which recommended its publication in the *Journal* of the AMA. The report stressed that although hypnosis might be used as a valuable therapeutic adjunct, those who use it should be aware of the complex nature of the phenomena involved.

The House endorsed recommendations that the AMA join other interested groups in setting up an expanded voluntary program, coordinated by the National Better Business Bureau, to eliminate objectionable advertising of over-the-counter medicines. The AMA was authorized to counsel with the Better Business Bureau in selection of a physicians' advisory committee, and its facilities were to be made available, so far as is feasible, in carrying out the program.

A national interprofessional code for physicians and attorneys prepared by the joint liaison committee of the AMA and the American Bar Association was approved.

The next annual session of the American Medical Association is scheduled for Atlantic City, June 8-12, 1959. The 1958 clinical meeting will be held in Minneapolis, December 2-5; the 1959 clinical meeting in Dallas, December 1-4.

Labeling Law Conference

Doctors will discuss model legislation for labeling hazardous substances at an American Medical Association conference in Chicago, July 25. The meeting, sponsored by the AMA's Committee on Toxicology, will discuss the Uniform Hazardous Substances Act, which has been drafted by the committee and is intended to close the gap in label legislation. Representatives from trade associations, toxicity testing laboratories, chemical trade unions, and other interested groups will be among the participants.

Approximately 17,000,000 Americans are or can expect in their lifetime to be wheezing, coughing, sneezing, or itching due to allergy, according to the publication, "Patterns of Disease," prepared by Parke, Davis and Company.

★ Texas Medical Association

New Life Insurance Plan Offered

Term life insurance at low association group rates is now available to members of the Texas Medical Association in a plan approved by the Council on Medical Economics after a 4 year study covering 27 proposed programs. The House of Delegates in April approved the idea of designating a life insurance plan for members.

Information about the new insurance program, the third offered under sponsorship of the Texas Medical Association since November, 1955, has been mailed recently to members of the Association. Offered by Great American Reserve Insurance Company of Dallas, the life insurance is available at a single premium of $100 per year, with benefits based on age of the insured: $26,000 up to age 35 years; $15,000 from 36 to 45; $7,500 from 46 to 55; $3,500 from 56 to 65; and $1,750 from 66 to 70 years, all ages being according to the nearest birthday. The insurance will terminate at age 70.

All members of the Texas Medical Association up to age 70 are eligible to apply for the new life insurance plan, although each is subject to physical examination and, on the basis of the results of the examination, may be excluded or charged an additional rate. Prior to age 60, the insured may convert or exchange his policy, without medical examination or other evidence of insurability, for any plan of life or endowment insurance issued by the company at that time. The amount of the converted policy may not exceed the death benefit in force on the date of exchange. The premium for the converted policy will be based on the insured's age at the date of conversion. The Council on Medical Economics will act as an adjudication committee on any question which may arise as the program becomes operative.

The insured may name and change the beneficiary and exercise all other rights of policy ownership. The spouse can own the contract on the member's life and the benefits may be assigned. The insurance is noncancellable by the underwriting company and is incontestable after 2 years from its issuance date except for nonpayment of premium. The insured has a choice of settlement options, and there is no restriction as to military service or as to commercial or private flying.

The insurance issued will go into effect when the individual policy is delivered to the insured and the first premium is paid. Premiums may be paid annually ($100), semiannually ($50.35), quarterly ($25.35), or monthly ($8.54). Premiums do not increase as the insured grows older; the amount of insurance is reduced.

No member may purchase more than one policy, nor may he purchase part of a policy.

Inquiries about the life insurance program may be addressed to the Texas Medical Association, 1801 North Lamar Boulevard, Austin.

Conference to Show Complaint Examples

What happens to complaints that go before county medical society grievance committees will be the subject of a panel discussion at the Public Relations Conference of the Texas Medical Association. The conference will be held in connection with other Association activities on the week end of September 6-7 in the headquarters building in Austin.

The audience and panel members will attempt to find solutions for the cases. What actually happened to each case will be told at the end of the discussion.

Also on the program for the conference will be three guest speakers, each discussing different phases of public relations. Representatives of various county societies will participate in a panel dealing with public relations problems and projects. Presidents, secretaries, public relations chairmen, and executive secretaries of county societies and presidents, public relations chairmen, and members of the executive boards of woman's auxiliaries are invited to attend.

Other activities during the September week end will include an orientation program and meetings of the Executive Council, committees, and councils of the Association.

The orientation program will include talks dealing with different aspects of organized medicine and with the various services which the Association provides for its members. The program is designed primarily for new members and for members who transfer from one county society to another; however, any member of the Association is welcome to attend.

Grievance Committee Procedure Changed

Professional complaints by one doctor against another doctor will now be handled by the board of censors of the component county medical society, according to an amendment adopted by the Texas Medical Association House of Delegates at its April meeting in Houston. The amendment in its original form was a resolution from the Tarrant County Medical Society.

The change will appear in this year's revised edition of the Constitution and By-Laws. Public charges against a doctor will continue to be handled by the county medical society's grievance committee.

★ County Societies

County Society News Briefs

Members of the *Bexar County Society* have been invited to join the United Physicians Fund of Bexar County, a nonprofit organization through which society members may pool their contributions to charity. During the past year, 96 doctors participated in disbursing $9,950 to charity. Members may join the fund by sending a minimum contribution of $100. Also under way in San Antonio are plans to form a bowling league which will consist of doctors, dentists, druggists, and detailmen. The proposed league will consist of 6 or 8 teams and will be sponsored by different drug manufacturers.

Dr. J. C. Jordan of El Paso spoke to the *Pecos-Jeff Davis-Presidio-Brewster Counties Society* on surgical technique and tips at its meeting June 3 at the Cathedral Mountain Lodge at Alpine.

The scientific program for the *McLennan County Society* was presented by Dr. Ellard M. Yow, Baylor University College of Medicine, Houston. Dr. Yow spoke on "An Epidemic of Hospital-Acquired Staphylococcal Infections." The society met May 13 at the Hillcrest Hospital in Waco.

The *Potter-Randall Counties Society* will make an effort to have Amarillo become a branch member of the University of Texas Postgraduate School of Medicine, its members decided at its May 12 meeting. The Rev. Robert M. Skinner, pastor of the First Presbyterian Church in Amarillo, presented "The Physician and the Clergyman" as the scientific program for the meeting.

WOMAN'S AUXILIARY

Civil Defense and the Auxiliary

People may be thinking "Disaster can't strike here."
It struck in Lampasas.
It struck in Texas City.
It struck in Dallas.

And it also can strike in the area where each lives. If it does, each family must be prepared to meet the emergencies of an aftermath of disaster.

The Federal Civil Defense Administration is an agency of the people, by the people, and for the people. From regional offices the FCDA assists, and coordinates local government activities in disaster planning.

The county medical society and auxiliary can provide leadership in planning, organizing, recruiting, and training for the civil defense program. Guidance for this may be obtained at the local civil defense office or Red Cross chapter.

William McGill is the Texas coordinator in the Division of Defense and Disaster Relief located in Austin. This arm of the executive department of our state government provides many program planning materials. The information is geared toward a preparedness or ability to meet disaster from enemy attack, forces of nature, or everyday accident.

Physicians and their wives would have a primary place of responsibility if an over-all emergency came to a community. An informed leadership is essential if we maintain our present way of life.

All Americans know to dial radio channels 640 or 1240 for civil defense instructions if disaster strikes, but more knowledge will be required of members of the medical auxiliary.

Annual reports reveal auxiliary members have qualified themselves to render first aid and teach first aid, and one group of former nurses do volunteer nursing to keep themselves informed. Members have been reminded to carry first aid supplies in their automobiles.

The distribution of thousands of personal health information cards by auxiliary members may prove to be a lifesaving factor in the event of an emergency. Properly filled out, the card would indicate that the bearer requires special treatment as a result of previous medical care.

By working together, the medical society and its auxiliary may serve the community and plan now for its survival.

—MRS. JAMES M. COLEMAN, Austin.

Texas Auxiliaries Cited For AMEF Contributions

The Woman's Auxiliary to the Texas Medical Association and four county auxiliaries in the state were cited for contributions to medical education at a luncheon in San Francisco on June 25 during the meeting of the American Medical Association.

An award of merit was presented to the Woman's Auxiliary to the Texas Medical Association by Dr. George F. Lull, Chicago, president of the American Medical Education

Foundation, at a luncheon at the Mark Hopkins Hotel. The award of merit cited the Woman's Auxiliary for its "outstanding contributions to the preservation and continuance of the high standards of medical education in the United States." Texas ranked in the first 10 in state per capita contributions to AMEF in 1957. Total raised by the Texas Auxiliary was $13,573.90.

Certificates of achievement were presented to four county auxiliaries in Texas for outstanding effort on behalf of AMEF. Recipients of certificates presented by Mrs. Paul C. Craig, Wyomissing, Pa., president of the Woman's Auxiliary to the AMA, were the Woman's Auxiliaries to the Bexar, Dallas, Harris, and Tarrant County Medical Societies.

Each auxiliary raised more than $1,000 in behalf of AMEF last year. While four county auxiliaries in Texas qualified for certificates of achievement, no other state earned more than two.

RECENT DEATHS

DR. BEDFORD F. BOYLSTON

Dr. Bedford Forrest Boylston, head of the orthopedic department at Baylor University College of Medicine, Houston, died March 22, 1958.

Dr. Boylston, the son of Leon L. and Lulalee (Holley) Boylston, was born September 25, 1916, at Aiken, S. C. He attended public schools in Aiken, S. C., and was graduated from Duke University at Durham, N. C., in 1937, and Jefferson Medical College at Philadelphia in 1941. Dr. Boylston served his internship and was later house surgeon at Bellevue Hospital in New York, was fracture resident at Presbyterian Hospital in New York and was orthopedic resident at Children's Hospital and senior orthopedic resident at Massachusetts General Hospital, both in Boston. He was a lieutenant in the United States Navy from 1944 to 1946. He moved to Houston in 1950 where he remained until his death. In Houston, he was chief of the orthopedic service of the Veterans Administration Hospital and a member of the active staffs of Jefferson Davis Hospital, Texas Children's Hospital, Methodist Hospital, and St. Luke's Hospital, as well as a member of the courtesy staff of all other Houston hospitals.

DR. BEDFORD F. BOYLSTON

A member of the Harris County Medical Society, he also belonged to the Texas Medical Association, the American Medical Association, the American Academy of Orthopedic Surgery, the Texas Orthopedic Society, and the Southern Medical Association. Dr. Boylston was a fellow of the American College of Surgeons, a diplomate of the American Board of Orthopedic Surgery, and president of the Houston Orthopedic Club. He was the author of several scientific papers and an enthusiastic teacher. He was a member of St. Mark's Episcopal Church.

Dr. Boylston married the former Miss Isabel Brickley in London, England, on December 10, 1945. She survives as do three children, Ann, Patricia, and Bedford, Jr., and his father, L. L. Boylston of Aiken, S. C.

DR. ZENO T. MARTIN

Dr. Zeno Thomas Martin of Austin died March 28, 1958.

The son of T. A. ond Martha (Hellman) Martin, he was born December 28, 1896, at San Antonio. He received his preliminary education at the University of Texas in Austin and was graduated from the University of Texas Medical Branch at Galveston in 1920. After an internship and residency at Philadelphia, he practiced at Austin, serving as city health officer and city physician and surgeon from 1922 to 1926. He moved to Johnson City in 1932 and returned in 1950 to Austin, where he was senior psychiatrist and assistant superintendent at Austin State Hospital.

DR. ZENO T. MARTIN

Dr. Martin was a member of the American Medical Association, the Texas Medical Association, and the Travis County Medical Society. He also held membership in the Southern Medical Association and was at one time a member of the Hays-Blanco Counties Medical Society. He was a veteran of World War I.

Survivors include his wife, the former Miss Lola Mae Naumann, whom he married January, 1932, and one daughter, Mrs. Martha Ola Shepperd of Burnet.

DR. J. R. MAXFIELD

Dr. James Robert Maxfield, Sr., one of the early users of roentgen ray for diagnosis, died March 20, 1958, in Dallas, after 57 years of medical practice.

Born October 28, 1871, in Smith County near Tyler, Dr. Maxfield was the son of William and Kaziah (Hicks) Maxfield. He attended public schools at Mt. Sylvan and Van. He also attended A. W. Orr College at Omen, teaching school for 9 years before entering medical school. He received his doctor of medicine degree April 4, 1901, from the Medical Department, Fort Worth University. He did postgraduate work at the Illinois School of Electro-Therapeutics, the Chicago Clinical School, Chicago Policlinic, and the Cook County Hospital, all at Chicago.

Dr. Maxfield practiced from 1901 to 1913 at Van and Grand Saline, serving as chief surgeon for the Morton Salt Company and the Texas Shortline Railroad and as local surgeon for the Texas and Pacific Railway. He practiced at Waco for 30 years before moving in 1943 to Dallas, where he was associated with his three sons. Dr. Maxfield brought the art of using roentgen ray for diagnosis to East

DR. J. R. MAXFIELD

Texas in 1904. He was the author of various scientific articles and held honorary doctor of medicine degrees from Oklahoma City University and the Baylor University College of Medicine. During World War II, he received a Selective Service certificate of merit.

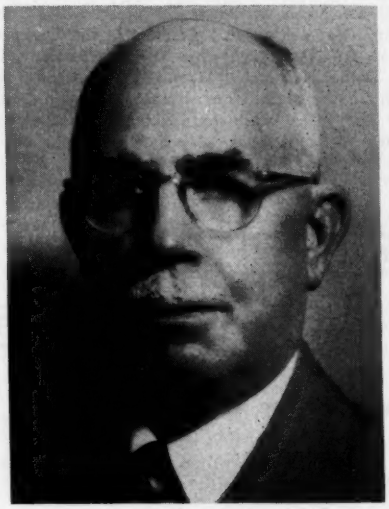
A past president and former member of the Van Zandt County Medical Society, Dr. Maxfield, at the time of his death, held membership in the Dallas County Medical Society, the Texas Medical Association, and the American Medical Association. He also had belonged formerly to the McLennan County Medical Society and the District 12 Medical Society. He was a member of St. Matthews Cathedral (Episcopal).

He married the former Miss Marie Streeter, September 29, 1909, at Waco. She survices as do three sons, Dr. J. R. Maxfield, Jr., and Dr. Jack G. S. Maxfield, both of Dallas, and Dr. William S. Maxfield, a lieutenant in the United States Navy stationed at Bethesda, Md.; and one daughter, Miss Marie Maxfield of Dallas.

DR. JAMES N. McLEOD

Dr. James Newton McLeod, Dallas obstetrician and gynecologist, died April 23, 1958.

Born in Pike, N. C., July 7, 1889, Dr. McLeod was graduated from Austin College at Sherman in 1914. He received his doctor of medicine degree from the University



DR. JAMES N. McLEOD

of Texas Medical Branch at Galveston in 1920 and interned at St. Paul's Hospital in Dallas. He was co-chief of the obstetrical staff at Parkland Hospital from 1927 to 1938. He was chief of the obstetrical staff of St. Paul's Hospital from 1929 to 1947 and served in various teaching capacities at St. Paul's School of Nursing from 1921 to 1940. Dr. McLeod was a veteran of World War I. He practiced in Dallas from 1921 until his death.

A member of the American Medical Association, Dr. McLeod also held membership in the Texas Medical Association and the Dallas County Medical Society. He was a fellow of the American College of Surgeons and a member of the Texas Association of Obstetricians and Gynecologists, the Dallas Southern Clinical Society, and the Dallas-Fort Worth Obstetrical and Gynecological Society. Dr. McLeod belonged to the First Presbyterian Church and the Rotary Club.

Survivors include his wife; two daughters, Mrs. Frances Sellers and Mrs. Mildred Keitz, both of Dallas; two sisters, Mrs. Paul Stanford of Houston and Mrs. Bob Smith of Onalaska; and one brother, Norman McLeod of Houston.

DR. W. M. CAMPBELL

Dr. William Murphy Campbell, who had practiced at Weatherford for 68 years, died March 8, 1958.

The son of William and Francis (O'Bryant) Campbell, he was born December 12, 1859, in Shelby County. He attended Add-Ran College (now Texas Christian University) and before entering medical school, did some farming and taught school. He was graduated from Vanderbilt School of Medicine, Nashville, Tenn., in 1890.

Dr. Campbell first became a member of the Texas Medical Association in 1904 and was elected to honorary membership in 1950. Dr. Campbell was also a member of the Palo Pinto-Parker-Young-Jack-Archer Counties Medical Society, American Medical Association, and the Texas Academy of General Practice. About 4 years ago, the board of trustees of the Parker County Hospital at Weatherford honored Dr. Campbell by renaming the hospital Campbell Memorial Hospital. He had been a lay speaker, elder, and member of the board of the Central Christian Church and taught the Campbell Bible Class for more than 35 years. He was a Mason.

He married the former Miss Annie Adams, who died in 1896. He later married the former Miss Ida Barnett, who died in 1954. Dr. Campbell is survived by five children,

DR. W. M. CAMPBELL

Price Campbell and Mrs. R. E. Davis, both of Abilene; Wilson Campbell and Mrs. John Todd, both of Weatherford; and Mrs. Jack Porter, Houston. Also three sisters, Mrs. Lee Walker and Mrs. W. J. Milmo of Weatherford and Mrs. Henry Walker of Fort Worth, survive.

DR. W. T. BLACK

Dr. W. T. Black, who was in general practice at Quitman for 56 years, died April 30, 1958, of a cerebral hemorrhage.

Dr. Black was born at Winston, Ga., on November 7, 1877, and moved to Redland in Wood County in 1880. He taught school at Redland, New Hope, and Liberty before starting to study medicine. He entered medical college in Dallas in 1901. He later attended Tulane University School of Medicine in New Orleans and was graduated from there with honors in 1910. Following 50 years of practice in Wood County, Dr. Black took over the directorship of the Wood County Health Unit, a position he held for 6 years. In 1956 Dr. Black was named "Senior Citizen" of Quitman at a special program in his honor.

A past secretary, president, and one of the original founders of the Wood County Medical Society, Dr. Black had been a member of the Texas Medical Association since 1904. Dr. Black also held membership in the First Baptist Church. He was a Mason and a life member of the Rotary Club. He was also active in other religious, civic, and political affairs of Wood County. At the age of 78, he was honored by athletes of Quitman High School for being team physician since football was first started at the school.

DR. W. T. BLACK

Members of the family who survive include his wife, the former Miss Amanda Lindley, whom he married December 24, 1905; a son, W. T. Black, Jr., Quitman; a daughter, Miss Imogene Black, Dallas; two sisters, Mrs. Myrtle McCrary of Quitman and Mrs. C. A. Peacock of Mineola; and one grandson, W. T. Black, III.

DR. V. L. McPHERSON

Dr. Vernon Laster McPherson, Dallas, died May 16, 1958, of cancer of the liver.

Dr. McPherson was born May 22, 1888, at Harmony, Ark., the son of James M. and Laura A. (Laster) McPherson. He attended schools at Coal Hill, Ark., and was grad-

DR. V. L. McPHERSON

uated from the University of Arkansas School of Medicine at Little Rock in 1913. He later did postgraduate work at Tulane University at New Orleans. After practicing medicine for 3 years in Fort Powson, Okla., and 10 years in Boswell, Okla., he moved to Dallas in 1926. He was a first lieutenant in the United States Army Medical Corps during World War I.

He was a member of the Dallas County Medical Society and the Texas Medical Association. While practicing in Oklahoma, he was president of the Choctaw County Medical Society. Dr. McPherson was also a thirty-second degree Mason, Scottish Rite, and a member of the Oak Cliff Presbyterian Church.

Members of the family who survive include his wife, the former Miss Sallie B. Clower, whom he married February 1, 1916, at Hugo, Okla.; four sisters, Mrs. E. J. Gouldrick and Mrs. H. L. Neeley, both of Dallas; Mrs. Allen Crain of Saskawa, Okla.; and Mrs. Beulah Neil of Crescent, Okla.; a brother, Guy McPherson of Alice; and a half-brother, Lynda McPherson of Lafayette, La.

DR. GARLAND McPHERSON

Dr. Garland McPherson of Hillsboro died March 17, 1958.

The son of Dr. A. B. and Lydia Elizabeth (Alley) McPherson, he was born July 27, 1908, at Lovelace. He attended Lovelace and Hillsboro schools, Hillsboro Junior College, and Baylor University at Waco. He studied a year at Baylor University College of Medicine in Dallas and received his doctor of medicine degree from the University of Tennessee at Memphis in 1934. He served his internship at San Bernardino County Hospital in California and took residency training in medicine at Colgin Hospital in Waco. He practiced at Itasca from 1936 to 1941, at Lovelace from 1944 to 1953, and at Hillsboro from 1953 until his death. In 1941 he was a member of the staff of the

DR. GARLAND McPHERSON

Veterans Administration Hospital at Waco and later served with the United States Public Health Service at Galveston.

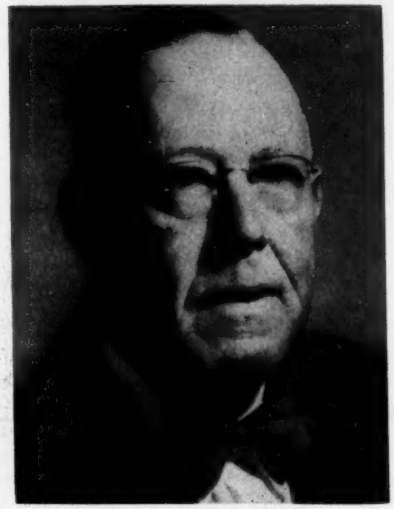
He was a president (serving in this capacity in 1939 and 1956) and a vice-president in 1955 of the Hill County Medical Society. He was a member of the Texas Medical Association and the American Medical Association. He belonged to Phi Beta Pi medical fraternity at the University of Tennessee. He served as a first lieutenant in the United States Air Force from 1942 to 1944.

Dr. McPherson married the former Miss Artie Daphne Salmon November 11, 1939. She survives as do one daughter, Lydia Gail of Hillsboro, and two brothers, Orvis and Marvin McPherson, both of Fort Worth.

DR. R. A. TRUMBULL

Dr. Robert A. Trumbull, active in medicine in Dallas for 45 years, died May 12, 1958.

The son of George A. and Katharine (Jaas) Trumbull, he was born July 3, 1889, at Dallas. His early education was received in Dallas public schools and Terrill Prep School. He was graduated from the Medical Department, Southwestern University, at Dallas in 1913 and interned at Dallas City Hospital (now Parkland Memorial Hospital). He practiced in Dallas from 1913 until his death.



DR. R. A. TRUMBULL

Dr. Trumbull held membership in the Dallas County Medical Society (of which he was a past president), the Texas Medical Association, and the American Medical Association. He served in the House of Delegates and as chairman of the Council on National Emergency Medical Service of the Texas Medical Association. Dr. Trumbull was also a charter member and past president of the Dallas Southern Clinical Society and chairman of the State Advisory Committee to the Selective Service System. He had been president of the St. Paul's Hospital staff. A thirty-second degree Mason, Dr. Trumbull was also a member of the Cross of Constantine, the Royal Order of Jesters, the Shrine, and the Highland Park Presbyterian Church, and a life member of the Dallas Athletic Club. He was vice-president and treasurer of Huey and Philp Company.

Dr. Trumbull was a major in World War I and was assigned to the Royal Air Force. During World War II, he was ranked as colonel in the Army Air Force and received the distinguished service medal.

Survivors include his wife; a daughter, Mrs. Norwood W. Beach, Jr. of Dallas; and four grandchildren.

MEMBERSHIP

TEXAS MEDICAL ASSOCIATION

JULY, 1958

The membership list which follows is compiled from names sent by county society secretaries to the state office. The names are listed by county societies within the fifteen districts. The number after each county listed below indicates the district in which the county is located.

Anderson—11
Andrews—2
Angelina—10
Aransas—6
Archer—13
Armstrong—3
Atascosa—5
Austin—9
Bailey—3
Bandera—5
Bastrop—7
Baylor—13
Bee—6
Bell—12
Bexar—5
Blanco—7
Borden—2
Bosque—12
Bowie—15
Brazoria—8
Brazos—12
Brewster—1
Briscoe—3
Brooks—6
Brown—4
Burleson—9
Burnet—7
Caldwell—7
Calhoun—8
Callahan—13
Cameron—6
Camp—15
Carson—3
Cass—15
Castro—3
Chambers—10
Cherokee—11
Childress—3
Clay—13
Cochran—3
Coke—4
Coleman—4
Collin—14
Collingsworth—3
Colorado—8
Comal—5
Comanche—4
Concho—4
Cooke—14
Coryell—12
Cottle—3
Crane—4
Crockett—4
Crosby—3
Culberson—1
Dallam—3
Dallas—14
Dawson—2
Deaf Smith—3
Delta—14
Denton—14
De Witt—8
Dickens—2
Dimmit—5
Donley—3
Duval—6
Eastland—13
Ector—2
Edwards—5
Ellis—14
El Paso—1
Erath—12
Falls—12
Fannin—14
Fayette—8
Fisher—2
Floyd—3
Foard—3
Fort Bend—8
Franklin—14
Freestone—11
Frio—5
Gaines—2
Galveston—8
Garza—2
Gillespie—5
Glasscock—2
Goliad—8
Gonzales—5
Gray—3
Grayson—14
Gregg—15
Grimes—9
Guadalupe—5
Hale—3
Hall—3
Hamilton—12
Hansford—3
Hardeman—3
Hardin—10
Harris—9
Harrison—15
Hartley—3
Haskell—13
Hays—7
Hemphill—3
Henderson—11
Hidalgo—6
Hill—12
Hockley—3
Hood—12
Hopkins—14
Houston—11
Howard—2
Hudspeth—1
Hunt—14
Hutchinson—3
Irion—4
Jack—13
Jackson—8
Jasper—10
Jeff Davis—1
Jefferson—10
Jim Hogg—6
Jim Wells—6
Johnson—12
Jones—13
Karnes—5
Kaufman—14
Kendall—5
Kenedy—6
Kent—2
Kerr—5
Kimble—4
King—2
Kinney—5
Kleberg—6
Knox—13
Lamar—14
Lamb—3
Lampasas—7
La Salle—5
Lavaca—8
Lee—7
Leon—11
Liberty—10
Limestone—12
Lipscomb—3
Live Oak—6
Llano—7
Loving—1
Lubbock—3
Lynn—2
McCulloch—4
McLennan—12
McMullen—6
Madison—9
Marion—15
Martin—2
Mason—4
Matagorda—8
Maverick—5
Medina—5
Menard—
Midland—2
Milam—12
Mills—4
Mitchell—2
Montague—13
Montgomery—9
Moore—3
Morris—15
Motley—3
Nacogdoches—10
Navarro—12
Newton—10
Nolan—2
Nueces—6
Ochiltree—3
Oldham—3
Orange—10
Palo Pinto—13
Panola—11
Parker—13
Parmer—3
Pecos—1
Polk—9
Potter—3
Presidio—1
Rains—14
Randall—3
Reagan—4
Real—5
Red River—15
Reeves—1
Refugio—6
Roberts—3
Robertson—12
Rockwall—14
Runnels—4
Rusk—11
Sabine—10
San Augustine—10
San Jacinto—9
San Patricio—6
San Saba—4
Schleicher—4
Scurry—2
Shackelford—13
Shelby—10
Sherman—3
Smith—11
Somervell—12
Starr—6
Stephens—13
Sterling—4
Stonewall—2
Sutton—4
Swisher—3
Tarrant—13
Taylor—13
Terrell—5
Terry—2
Throckmorton—13
Titus—15
Tom Green—4
Travis—7
Trinity—9
Tyler—10
Upshur—15
Upton—4
Uvalde—5
Val Verde—5
Van Zandt—14
Victoria—8
Walker—9
Waller—9
Ward—1
Washington—9
Webb—6
Wharton—8
Wheeler—3
Wichita—13
Wilbarger—13
Willacy—6
Williamson—7
Wilson—5
Winkler—1
Wise—13
Wood—11
Yoakum—2
Young—13
Zapata—6
Zavala—5

(Int.) indicates Intern Membership. (Hon.) indicates Honorary Membership. (Emer.) indicates Membership Emeritus. (Inac.) indicates Inactive Membership. (Mil.) indicates Military Membership.

FIRST DISTRICT

Dr. C. E. Oswalt, Jr., Fort Stockton, Councilor

EL PASO

Alexander, M. L., (Hon.), Canutillo.
Appel, Saul B., 1201 1st Natl. Bldg., El Paso.
Arguelles, F. L., (Hon.),
401 S. Stanton, El Paso.
Autrey, Walter Claude,
7792-C Franklin Rd., El Paso.
Avner, Saul L., 330 Morgan Ave., El Paso.
Awe, Chester D., 1501 Arizona St., El Paso.
Ayub, Pablo, 4622 Alameda Ave., El Paso.
Baca, Francisco E., 624 Caples Bldg., El Paso.
Barrett, Frank O., 1501 Arizona St., El Paso.
Basom, W. Compere,
520 Montana St., El Paso.
Bell, Herbert J., 1501 Arizona St., El Paso.
Bennett, J. Travis, 1501 Arizona St., El Paso.
Bennett, Raymond J.,
1501 Arizona St., El Paso.
Bernard, Jack A., 1501 Arizona St., El Paso.
Bernell, Edward C.,
1017 1st Natl. Bldg., El Paso.
Black, Arthur P., 525 Montana St., El Paso.
Black, Gordon L., 1501 Arizona St., El Paso.
Blanco, Victor M., Banner Building, El Paso.
Boehler, Clement C.,
1501 Arizona St., El Paso.
Bornstein, Frederick P.,
Providence Mem. Hosp., El Paso.
Boverie, Robert F.,
415 E. Yandell Blvd., El Paso.
Bozzell, James D., 1501 Arizona St., El Paso.
Breck, Louis W., 520 Montana St., El Paso.
Britton, Bloyce H.,
505 1st Natl. Bldg., El Paso.
Britton, W. W., (Hon.),
2704 Fort Blvd., El Paso.
Brunner, George, 1208 Mills Bldg., El Paso.
Budwig, Ira A., 1501 Arizona St., El Paso.
Byrne, Basil K., 1501 Arizona St., El Paso.
Cameron, David M.,
1501 Arizona St., El Paso.
Campbell, Robert P., (Mil.),
WBAH, El Paso.
Cardwell, Robert J.,
414 Banner Bldg., El Paso.
Carnes, David M., 125 River St., Ysleta.
Carpenter, Gray E.,
2323 Montana St., El Paso.
Carter, Joe C., 214 Banner Bldg., El Paso.
Casavantes, Luis, 914 N. Stanton St., El Paso.
Caylor, Robert N., 415 E. Yandell, El Paso.
Clayton, Ralph S.,
415 E. Yandell Blvd., El Paso.
Cohen, Manley B., 417 E. Yandell, El Paso.
Coldwell, William I.,
800 Montana St., El Paso.
Cooley, Ben H., 800 Montana St., El Paso.
Cooper, Arlin B., 1501 Arizona St., El Paso.
Craige, Branch, 1501 Arizona St., El Paso.
Crossett, Egbert Samuel,
415 E. Yandell, El Paso.
Cummins, Erwin J.,
1015 Mills Bldg., El Paso.
Curtis, Wickliffe R.,
1501 Arizona St., El Paso.
Damiani, Ann B., 626 Mills Bldg., El Paso.
Davidson, Maurice C.,
1501 Arizona St., El Paso.
Davis, George R., 4949 N. Mesa, El Paso.
Davis, W. J., (Hon.),
Rt. 1, Box 80-A, Anthony, N. M.
Del Campo, Dante,
5737 Trowbridge, El Paso.
Demarest, Harry W.,
5532 Bandy Road, El Paso.
Deter, Russell L., 1501 Arizona St., El Paso.
Dietrich, Hervey W.,
415 E. Yandell, El Paso.
Domenicali, Pete, Jr.,
7705 N. Loop Rd., El Paso.
Don, Rita Louisa, 616 Mills Bldg., El Paso.
Dotson, J. C., 800 Montana St., El Paso.
Dow, Antonio 1023 Mills Bldg., El Paso.
Dutton, Loraine O.,
616 Mills Bldg., El Paso.
Eck, Andrew J., 5970 Alameda Ave., El Paso.
Edwards, George M., (Hon.),
2507 Nasworthy Dr., San Angelo.
Egbert, O. Edward, Jr.,
2526 Frankfort Ave., El Paso.
Egbert, Orville E., 1501 Arizona St., El Paso.
Eidinoff, Harold, 1501 Arizona St., El Paso.
Ellis, Jack Reese, 1501 Arizona St., El Paso.
Elsberg, Charles P., 800 Montana, El Paso.
Emmett, John E., 520 Montana, El Paso.
Engel, Eugen, 221-A S. Stanton St., El Paso.
Epstein, I. M., 525 Montana, El Paso.
Ertl, Edward J., 4950 Montoya Dr., El Paso.
Evans, Fred G., 415 E. Yandell, El Paso.
Evans, Ward, 414 Banner Bldg., El Paso.
Ewalt, Donald H., (Sec'y.),
1501 Arizona St., El Paso.
Feener, Lester C., 404 Banner Bldg., El Paso.
Fernandez, Carlos A.,
5980 Alameda Ave., El Paso.
Floyd, Joe R., 1501 Arizona St., El Paso.
Gaddis, Leo R., 1218 Mills Bldg., El Paso.
Gaddis, William R.,
1218 Mills Bldg., El Paso.
Gaddy, S. J., 912 N. Mesa Ave., El Paso.
Galatzan, Joe S., 2911 Pershing Dr., El Paso.
Gallagher, Paul, (Hon.),
1423 Del Rio Blvd., Eagle Pass.
Gants, Robert T., (Mil.),
Wm. Beaumont Hosp., Fort Bliss.
Gardea, Raymond A.,
4618 Alameda Ave., El Paso.

Garrett, Henry D., 1501 Arizona St., El Paso.
Gemoets, Albert A.,
3726½ Alameda, El Paso.
Gibson, H. M., Jr.,
209 Med. Arts. Bldg., El Paso.
Gilmore, Richard C., Jr.,
927 Raynolds Blvd., El Paso.
Ginn, L. Holmes, Jr., (Mil.),
Wm. Beaumont Hosp., El Paso.
Gladstone, Larry A., (Mil.),
1200 N. Ochoa, Apt. 8, El Paso.
Goldfarb, Irvin J.,
415 E. Yandell Blvd., El Paso.
Golding, Frank C., 1501 Arizona St., El Paso.
Goodloe, B. Lynn, 415 E. Yandell, El Paso.
Gorman, James J.,
701 1st Natl. Bldg., El Paso.
Green, Charles L.,
105 Med. Arts. Bldg., El Paso.
Green, J. Leighton,
1501 Arizona St., El Paso.
Haan, Robert E., 520 Montana St., El Paso.
Hardie, Bradford,
403 1st Natl. Bldg., El Paso.
Hart, Maynard S., 1501 Arizona St., El Paso.
Hatfield, Haskell D.,
1501 Arizona St., El Paso.
Higdon, Donald A., Box 938, Fabens.
Hinton, Joseph H., 800 Montana St., El Paso.
Holt, Russell, 415 E. Yandell, El Paso.
Homan, Ralph H., 1501 Arizona St., El Paso.
Homan, Robert B., Jr.,
1501 Arizona St., El Paso.
Hornedo, Manuel D.,
118 W. Missouri St., El Paso.
Hornisher, J. J., 4521 Leeds, El Paso.
Hunter, C. D., 800 Montana St., El Paso.
Hunter, Robert C., Jr., (Mil.),
WBAH, El Paso.
Jenness, Burt F., 3418 Fort Blvd., El Paso.
Johnstone, John H., 125 River St., Ysleta.
Jones, W. A., 1501 Arizona St., El Paso.
Jordan, Gerald H., (Pres.),
1501 Arizona St., El Paso.
Kearney, William W., Hawkeye, Iowa.
Keller, Nathan H.,
El Paso Natl. Bldg., El Paso.
King, Sam R., 607 El Paso Natl., El Paso.
Kleban, M. Nathan,
415 E. Yandell Blvd., El Paso.
Kosicki, Zigmund W., 520 Montana, El Paso.
Kurita, Kenneth S., 2407 Grant Ave., El Paso.
Landis, Gilbert, 1501 Arizona, 3C, El Paso.
Leigh, Harry, 411 Banner Bldg., El Paso.
Leonard, Morton H.,
520 Montana St., El Paso.
Licon, Francisco, 3127 Alameda Ave., El Paso.
Liddell, Thos. C.,
1209 1st Natl. Bldg., El Paso.
Lipsey, Billy C., Box 487, Van Horn.
Logsdon, Charles P. C.,
Med. Arts Bldg., El Paso.
Lombard, Julian H.,
4620 Emory Way, El Paso.
Lorentzen, Wayne L., (Mil.),
U. S. Naval Hosp., Corpus Christi.
Lozano, Porfirio, 417 S. Stanton St., El Paso.
Luckett, Alfred E., 1501 Arizona St., El Paso.
Lukowski, John L., 3313 Fort Blvd., El Paso.
Lyman, Harold D., (Mil.),
139 Ct. House, El Paso.
Marshall, Howard J. H.
1501 Arizona St., El Paso.
Martin, John D., 405 Mills Bldg, El Paso.
Martin, T. Sterling,
1501 Arizona St., El Paso.
McNeil, James Lewis,
1501 Arizona St., El Paso.
McVaugh, Charles C.,
616 Mills Bldg., El Paso.
Milchen, Carl, 7505 N. Loop Rd., El Paso.
Miller, John B., 3313 Fort Blvd., El Paso.
Miskimins, J. Harry, Mills Bldg., El Paso.
Molinar y Rey, Jose, (Inac.),
1106 Mundy Ave., El Paso.
Molinar Z, Ramon, 306 S. Stanton, El Paso.
Molloy, Maxwell S., V. A. Hosp., Kerrville.
Morrison, John E., Mills Bldg., El Paso.
Morrow, Walter G., Jr.,
1001 1st Natl. Bldg., El Paso.
Moses, Lyndon D., 8200 Dyer St., El Paso.
Multhauf, A. W.,
1315 1st Natl. Bldg., El Paso.
Mutnick, Reuben, 112 S. Concepcion, El Paso.
Nering, A. Robert, 1st Natl. Bldg., El Paso.
Palafox, Mario, 520 Montana St., El Paso.
Perry, Alvin L., 209 Med. Arts Bldg., El Paso.
Persky, Murray, 1501 Arizona, 15C, El Paso.
Peticolas, John D.,
214 Banner Bldg., El Paso.
Phillips, Richard J., (Mil.),
U. S. Army Hosp., Tooele, Utah.
Pierce, Wendell L., 415 E. Yandell, El Paso.
Ponsford, John A., 1501 Arizona St., El Paso.
Postlewaite, Jack C.,
1501 Arizona St., El Paso.
Price, Elwyn D., (Inac.),
1013 Mills Bldg., El Paso.
Prieto, Philip M., 1501 Arizona St., El Paso.
Quirarte, Humberto,
1235 1st Natl. Bldg., El Paso.
Ravel, Vincent M., 616 Mills Bldg., El Paso.
Redelfs, John Wright,
1501 Arizona St., El Paso.
Rennick, Charles F.,
1218 Mills Bldg., El Paso.
Reynolds, Chester Lee,
3016 Wyoming St., El Paso.
Rheinheimer, E. W.,
415 E. Yandell, El Paso.
Rice, Herman 1501 Arizona St., El Paso.
Rigney, Paul, 821 E. Yandell Blvd., El Paso.
Rising, Ernest E., Jr., (Mil.),
Fed. Reformatory, El Reno, Okla.
Rissler, Ross W., 2001 Grant Ave., El Paso.
Robbins, Jacob B.,
927 1st Natl. Bldg., El Paso.
Rodarte, Ruben B., 401 S. Stanton, El Paso.
Rogde, Jacob, 315 Mills Bldg., El Paso.
Rogers, S. Perry, 1501 Arizona St., El Paso.
Ruiz, Augustin M.,
102 Val Verde St., El Paso.
Rush, Jack T., (Mil.),
Fitzsimons Army Hosp., Denver, Colo.
Schlenker, George M.,
415 E. Yandell Blvd., El Paso.
Schuessler, Willard W.,
1501 Arizona St., El Paso.
Schuster, Frank P., 1st Natl. Bldg., El Paso.
Schuster, Frank P., Jr., (Mil.),
105 Water St., Galveston.
Schuster, Stephen A., 1st Natl. Bldg., El Paso.
Shanley, T. J. B.,
8903 Old County Rd., Ysleta.
Shugart, Joseph A.,
1501 Arizona St., El Paso.
Skemp-Nystrom, Harriet, Box 25, Canutillo.
Smith, Leslie M., 1501 Arizona St., El Paso.
Sorensen, Alfred, 600 Loretto Rd., El Paso.
Soto, Raul C., 522 Caples Bldg., El Paso.
Spearman, Maurice P.,
1501 Arizona St., El Paso.
Spier, Erich, 415 E. Yandell Blvd., El Paso.
Stanfill, Chas. M.,
415 E. Yandell Blvd., El Paso.
Stapp, Celso C., 800 Montana St., El Paso.
Stern, J. Edward, 626 Mills Bldg., El Paso.
Stevens, B. F., (Hon.),
217 Blacker, El Paso.
Stowe, Jesson L., 2323 Montana St., El Paso.
Stratemeyer, W. P.,
415 E. Yandell Blvd., El Paso.
Taber, Ben Zion, 201 Espana, El Paso.
Thayer, Robert H., 1501 Arizona St., El Paso.
Thomas, Merle D.,
1501 Arizona St., El Paso.
Thompson, Robert F.,
818 Mills Bldg., El Paso.
Treece, Angus A., Fabens.
Tubbs, William M., 3031 Altura, El Paso.
Turner, George, 1501 Arizona St., El Paso.
Unger, Albert H.
911 Huckleberry St., El Paso.
Vance, James, (Hon.),
1717 N. Mesa Ave., El Paso.
Vandevere, William E.,
1001 1st Natl. Bldg., El Paso.
Vargas G. Francisco, 408 S. Stanton, El Paso.
Varner, Harry H., 1501 Arizona, 5E, El Paso.
Vaughan, W. Hunter,
1501 Arizona St., 2B, El Paso.
Verosky, John M., 1501 Arizona St., El Paso.
Villareal, Leopoldo, Caples Bldg., El Paso.
Vinikoff, Maurice R.,
318 Mills Bldg., El Paso.
Voigt, Alfred E., 4806 Montana St., El Paso.
Von Briesen, Delphin,
1501 Arizona St., El Paso.
Walker, Jack A., Jr.,
1501 Arizona St., El Paso.
Walker, Newton F., 1st Natl. Bldg., El Paso.
Webb, Charles E., 1501 Arizona St., El Paso.
White, John E., 1501 Arizona, 2A, El Paso.
Wilcox, Leigh E., 1501 Arizona St., El Paso.
Wollmann, Walter W.,
2001 Grant Ave., El Paso.
Zacharias, Otis G., 705 E. River St., El Paso.

PECOS-JEFF DAVIS-PRESIDIO-BREWSTER

Blackwell, James H., (Hon.), Marfa.
Blow, Frank T., (Hon.), Alpine.
Gaddis, Don A., Fort Davis.
Gipson, James F.,
211 N. Nelson, Fort Stockton.
Hill, Malone V., 123 N. Sixth, Alpine.
Hoffman, George A.,
106 S. Main, Fort Stockton.
Hundley, John C., (Sec'y.),
Box 466, Fort Stockton.
Kelley, Wm. N., (Hon.),
P. O. Box 125, Balmorhea.
Lockhart, William E., Jr., Alpine.
O'Donnell, John W., Alpine.
Oswalt, Chas E., Jr.,
201 N. Water St., Fort Stockton.
Pate, John W., (Pres.),
803 E. Holland Ave., Alpine.
Ponton, Arvel R., Jr., Alpine.
Sexton, Jack M., 102 N. Persimmon, Sanderson.
Sherrod, Vincent A., Box 608, Iraan.
Sibley, D. J., Jr., Box 367, Fort Stockton.
Stover, Walter H., Marfa.
Wright, Joel E., Box 697, Alpine.

REEVES-WARD-WINKLER-LOVING-CULBERSON-HUDSPETH

Avery, Harlow F.,
#4 Constitution, Hingham, Mass.
Barnett, Arthur J., 310 S. Gary, Monahans.
Black, Wilmer D., (Hon.),
1702 Washington St., Pecos.
Briere, Arnold C., 8th & Elm, Pecos.
Camp, Jim, Pecos.
Campbell, Charles F., 110 N. Poplar, Kermit.
Denney, Ernest E., 909 S. Robinson, Kermit.
Dunn, John P., Pecos.
Hay, Bruce H. H., 401 Ross Blvd., Pecos.
Heath, Joe D., 113 S. Mulberry, Kermit.
Jones, H. Wayne,
310 S. Gary Ave., Monahans.
Kunstadt, Paul, Monahans.
Lindley, Harold, Pecos.
McClure, Wayne H., Kermit.
Munk, Otto, Monahans.
Peddicord, Harper, II, 900 Jeffe Dr., Kermit.
Peddicord, Orene W., 900 Jeffe Dr., Kermit.
Prout, Fred J., Monahans.
Reedy, Jack D., (Sec'y.),
1703 W. Fourth St., Pecos.
Rehmeyer, Walter O., Monahans.
Roberts, Rufus A., Pecos.
Robinson, Cecil A., Box 487, Kermit.
Robinson, Lila Rose, Box 487, Kermit.
Schmidt, Ed W., (Pres.), Pecos.
Wight, Bennett A., 113 S. Mulberry, Kermit.

SECOND DISTRICT

Dr. Henrie E. Mast, Midland, Councilor

ANDREWS-ECTOR-MIDLAND

Autry, Paul G., 2010 W. Illinois, Midland.
Barganier, John H.,
3003 Eastover Dr., Odessa.
Bauman, John E.,
413 N. Lincoln Ave., Odessa.
Bobo, Thomas C., 805 West Wall, Midland.
Boone, Martin H., Jr.,
210 North C St., Midland.
Brantly, E. Clayton, Jr.,
1217 E. Tenth St., Odessa.
Bryan, John N., 1600 N. Texas St., Odessa.
Bugg, Robert N., 208 N. Garfield, Midland.
Cantrell, David E., 516 W. 4th St., Odessa.
Casey, James G., P. O. Box 1544, Andrews.
Chapple, James H., (Inac.),
P. O. Box 5366, Midland.
Clark, John L., Jr., 1200 N. Texas, Odessa.
Coleman, Jesse L., 210 North C St., Midland.
Connery, David B., 2006 W. Ohio, Midland.
Curry, Dale W., 1200 N. Texas, Odessa.
Darwin, Lloyd K.,
1600 N. Texas Ave., Odessa.
Dempsey, Edwin B.,
P. O. Box 1987, Andrews.
Driscoll, Edward T.,
2010 W. Illinois, Midland.
Elliott, Thomas J., Box 1631, Odessa.
Elliott, Vance J., Medical Arts Clinic, Odessa.
Finch, Albert B., 1200 N. Texas Ave., Odessa.
Gomillion, Jesse D., Western Clinic, Midland.
Gooch, J. Oliver, Medical Arts Bldg., Midland.
Grafa, Barney G., Jr.,
1806 W. Wall, Midland.
Grammer, John C.,
501 Andrews Hwy., Midland.
Green, Wilbur K.,
404 N. Washington, Odessa.
Greenlee, Ralph G.,
401 N. Garfield, Midland.

Greenlees, David L., 518 W. 4th St., Odessa.
Grice, Marvin Edward,
313-D N. Alleghaney, Odessa.
Harris, Robert L., 2914 Chisum, Odessa.
Hays, Alan L., Headlee Clinic, Odessa.
Headlee, Emmet V., Box 3112, Odessa.
Hestand, Haskell E., 421 N Golder, Odessa.
Horne, Albert M., 2200 W. Illinois, Midland.
Horton, George W., 413 N. Lincoln, Odessa.
Hubbard, Prevost, Jr., 517 W. 4th St., Odessa.
Hunsaker, R. Dale,
2203 W. Illinois, Midland.
Hunt, H. Lynn, Jr., 421 N. Golder, Odessa.
Hunt, Jackie H., 408 N. Washington, Odessa.
Hutcheson, Zenas W., Jr., (Pres.),
P. O. Box 1987, Andrews.
Johnson, Chester R.,
108 N. Andrews Hwy., Midland.
Johnson, Homer B.,
501 Andrews Hwy., Midland.
Johnson, Reinhold E.,
3318 W. Michigan Ave., Midland.
Kirk, Earl H., 314 N. Alleghaney, Odessa.
Lang, Garland H., 108 N. Garfield, Midland.
Lekisch, Kurt, Box 852, Midland.
Lewis, Robert F.,
313-B N. Alleghaney, Odessa.
Loring, Milton J. 2001 W. Wall St., Midland.
Lunn, William W.,
408 N. Alleghaney, Odessa.
Madsen, Martha E.,
2200 W. Illinois, Midland.
Marinis, Thomas P.,
210 N. Garfield, Midland.
Mast, Henrie E., 2203 W. Illinois, Midland.
Mast, John R., 2203 W. Illinois, Midland.
McAlister, Joseph H.,
313-B N. Alleghaney, Odessa.
McCullough, Edison W.,
1415 N. Big Spring, Midland.
McIntire, Thornton S.,
601 W. 4th St. Odessa.
Melton, Thos. June, Jr.,
501 Andrews Hwy., Midland.
Mickle, Edwin R., 2011 West Ohio, Midland.
Mood, George F., 2203 W. Illinois, Midland.
Mullins, Donald H., (Int.),
5422 Lincrest Lane, Houston.
Nichols, Myron McCall,
2203 W. Illinois, Midland.
Novak, Theodore W., 413 N. Lincoln, Odessa.
Oehlschlager, F. Keith,
1208 W. 10th, Odessa.
Payne, William T.,
408 N. Alleghaney, Odessa.
Penn, Rhesa L., Jr.,
2003 West Ohio, Midland.
Rader, J. Paul, 313 N. Alleghaney, Odessa.
Rainer, James W.,
1200 N. Texas St., Odessa.
Ramsey, Richard R.,
P. O. Box 1987, Andrews.
Simpson, Fredric E.,
410 N. Washington, Odessa.
Tannenholz, Harold S.,
510 N. Lincoln, Odessa.
Tompkins, Harry H., Jr., (Sec'y.),
P. O. Box 1987, Andrews.
Turner, Jack Lee, 601 W. 4th, Odessa.
Walker, H. Glenn,
1737 Sunset, Apt. 11, Houston.
Wallace, Virgle W.,
1217 E. Tenth St., Odessa.
Walton, Jack R., 2011 W. Ohio, Midland.
White, Robert N.,
210 North C St., Midland.
Wiesner, William A.,
406 N. Washington, Odessa.
Williams, Glenn R.,
413 N. Lincoln, Odessa.
Wood, John K., 601 W. 4th St., Odessa.
Wood, Murray, (Dead).
Wright, Robert L., 601 West Fourth, Odessa.
Wyvell, Dorothy B., 307 North M, Midland.
Zinterhofer, Louis J.,
Box 71-C, Rt. 2, Midland.

BORDEN-DICKENS-GARZA-KENT-KING-SCURRY-STONEWALL

Alexander, Arthur B., Box 694, Ruidoso, N. M.
Archer, James T., Box 395, Spur.
Cockrell, C. Ray, 2612 Avenue R., Snyder.
Dillaha, Carl A., Jr., P. O. Box 1086, Snyder.
Hartley, Thomas F., (Sec'y.),
P. O. Box 1086, Snyder.
Jones, Wilton N., 2601 Avenue F., Snyder.
Martin, Edward H., Box 1438, Spur.
Nichols, Pike C., (Hon.),
313 E. Hill St., Spur.
Pierce, Robert B., 2811 Avenue S., Snyder.
Raines, John W., Snyder Hosp Clinic, Snyder.
Redwine, Harry P., (Pres.), Box 295, Snyder.
Rogers, Edward A., Jr.,
Medical Arts Bldg., Snyder.
Ward, Harry W., Rt. 3, Box 21-A, Snyder.
Wasson, Robert F., (Int.),
6737 Kenwell, Dallas.

DAWSON-LYNN-TERRY-GAINES-YOAKUM

Bailes, Jerry Ray, 602 West Tate, Brownfield.
Barnes, Louis R., Jr.,
Seagraves Clinic, Seagraves.
Black, Douglas B., Box 90, Lamesa.
Daniell, Alfred H., Brownfield.
Dow, Harold D., Box 546, Seminole.
Frazier, Sam Z., Lamesa.
Greenfield, Keller P.,
Box 1096, Denver City.
Hill, Wayne C., Brownfield.
Hood, Steve E., Jr.,
Gaines Clinic Hosp., Seminole.
Knox, Cecil B., Jr., (Sec'y.),
Box 1026, Brownfield.
Koberg, Frederick J., Seminole.
Lehman, Joe M., (Mil.),
2113 South S St., Fort Smith, Ark.
Loveless, James C., (Hon.),
Box 500, Lamesa.
McKay, J. Vernon, 613 S. 1st St., Lamesa.
Powers, Ace G.,
Seagraves Clinic Hosp., Seagraves.
Price, Noble H., Lamesa.
Prohl, Emil H., Tahoka.
Puckett, John P., (Pres.), Lamesa.
Rumbo, Noble L., Box D, O'Donnell.
Seale, Francis E., 1008 N. 3rd St., Lamesa.
Sharp, Joseph E., Denver City.
Smith, Alfred H., Lamesa.
Staker, Norman W., Lamesa.
Thomas, C. Skiles, Tahoka.
Tinley, Robert E., Denver City.
Treadaway, Thomas L., Brownfield.
Watts, Maurice A., Denver City.

HOWARD-MARTIN-GLASSCOCK

Bennett, Marion H.,
411 E. 9th St., Big Spring.
Boyett, Eleanor Sue, Box 191, Big Spring.
Broadrick, Broadway, Drawer 949, Big Spring.
Brohn, Alfred J., P. O. Box 882, Big Spring.
Burnett, Jack H., Jr.,
811 Main St., Big Spring.
Carson, Arch D., 1500 Gregg, Big Spring.
Conklin, Quinton D., Box 1487, Big Spring.
Cowper, Roscoe B. G., Box 111, Big Spring.
Dillon, George F., 811 Main St., Big Spring.
Fish, John H., (Sec'y.),
Box 1191, Big Spring.
Friedewald, Vincent E.,
811 Main St., Big Spring.
Hall, Granville T.,
P. O. Box 1191, Big Spring.
Hogan, John E., Box 991, Big Spring.
Horbaly, William, Box 231, Big Spring.
Lurting, Frederick W.,
811 Main St., Big Spring.
Malone, Phocian W., Box 991, Big Spring.
Marcum, Carlo B., 811 Main St., Big Spring.
Mays, Floyd R., Jr., Box 191, Big Spring.
Peacock, George E., 1500 Gregg, Big Spring.
Sanders, J. Virgil, Box 191, Big Spring.
Sanders, Nell W., P. O. Box 191, Big Spring.
Swift, Edward V., 811 Main St., Big Spring.
Talbot, Milton W., Jr.,
811 Main St., Big Spring.
Thomas, Clyde E., Jr.,
Howard Co. Hosp. Fdn., Big Spring.
Williams, Frankie E.,
Big Spring Sta. Hosp., Big Spring.
Williamson, Thos. J.,
411 E. 9th St., Big Spring.
Wilson, Iva G., 811 Main St., Big Spring.
Wood, G. Hardin, (Pres.),
Permian Bldg., Big Spring.
Woodall, Jack M., P. O. Box 991, Big Spring.
Worthy, Louise Bennett,
Drawer 949, Big Spring.

NOLAN-FISHER-MITCHELL

Barker, Frank R., Peters Clinic, Sweetwater.
Callan, Chester M., Box 488, Rotan.
Callan, Chester U., Rotan.
Chinn, John H., Jr.,
505 Chestnut, Colorado City.
Cowan, Seth B.,
505 Chestnut St., Colorado City.
Cowan, W. Kenneth,
505 Chestnut St., Colorado City.
Crymes, J. Melvin, Colorado City.
Fortner, Amos H., Sweetwater.
Gollihar, William P., (Sec'y.),
Young Clinic, Sweetwater.
Hood, Francis T. N., Jr.,
301 Locust, Sweetwater.
Johnson, Bruce H., Loraine.
Johnson, Clark A.,
Young Medical Center, Sweetwater.
Johnson, J. Frank., Rotan.
LeBleu, Bennie, P. O. Box 473, Rotan.
Loeb, Sam A., Sweetwater.
Logsdon, Harry A., Colorado City.
Peavy, J. E., 11908 Oak Trail, Austin.
Peters, Roland O., Sweetwater.
Price, Robert L., Sweetwater.
Rhode, Oscar E., Colorado City.
Rhode, William S.,
505 Chestnut St., Colorado City.
Richardson, James K.,
1301 Hailey, Sweetwater.
Rudd, Laurence H., Box 1266, Colorado City.
Supowit, S. F., 500 Oak St., Sweetwater.
Terry, Joseph C., Loraine.
Wilkinson, Robert T., Roby.
Young, James W., 1401 Hailey, Sweetwater.
Young, Tom D., (Pres.), Sweetwater.

THIRD DISTRICT

Dr. Robert A. Neblett, Canyon, Councilor

ARMSTRONG-DONLEY-CHILDRESS-COLLINGSWORTH-HALL-WHEELER

Blackketter, Donald E., (Sec'y.),
113 East 2nd St., Shamrock.
Butler, Robert G., Jr.,
Second & Ave. E, Childress.
Cariker, Fred H., Childress.
Carroll, William A., (Hon.),
1615 Monroe St., Amarillo.
Chaffin, Curtis R.,
206 North Main, Shamrock.
Clark, Robert E., Jr., Box 111, Memphis.
Fox, Grover C., Childress.
Fox, Jack F., 801 Commerce St., Childress.
Gooch, James W., Shamrock.
Goodall, O. R., Memphis.
Holcomb, Carter, Wellington.
Hunt, Thurman A., Memphis.
Jenkins, O. L., (Hon.),
9330 Forest Hills, Dallas.
Jernigan, James H., (Hon.), Childress.
Jeter, Perry R., (Hon.), Childress.
Jones, Charles B., Wellington.
Jones, John Wm., Box 266, Clarendon.
Lester, Joseph K.,
113 East 2nd St., Shamrock.
Nicholson, Harold E., Sr., Wheeler.
Nicholson, Harold E., Jr., Wheeler.
Odom, James A., (Hon.), Box 706, Memphis.
Roberts, Oran M., 104 East Second, Shamrock.
Smith, George W., Adair Hosp., Clarendon.
Stevenson, Harold R., Memphis.
Townsend, Shell H., Childress.
Walker, Glenn R., (Pres.), Wheeler.
Watkins, Dale V., Wellington.
Westenburg, Jacobus J., Childress.

DALLAM-HARTLEY-SHERMAN-MOORE

Askins, J. Robert, Jr.,
723 Bliss Ave., Dumas.
Brown, Thomas G., P. O. Box 326, Dumas.
Coventry, William V.,
115 W. 5th St., Dumas.
Cunningham, John H.,
201 Texas Blvd., Dalhart.
Elston, Fredrick A., P. O. Box 127, Sunray.
Gutekunst, Roscoe A.,
201 Texas Blvd., Dalhart.
Hays, Johnnie W., 214 E. Fifth, Dumas.
Meredith, Duane W., (Pres.),
214 E. 5th St., Dumas.
Moore, Victor R., Box 1108, Dalhart.
Pieratt, Karl W., 124 Amherst, Dumas.
Purgason, John R., Box 535, Dumas.
Reed, Emil P., (Sec'y.), 101 Beard, Dumas.
Richardson, O. J., 201 Bliss, Dumas.
Smith, Paul E., Stratford.
Wheeler, Jim E., 201 Bliss, Dumas.
Wright, Byron W., 214 E. 5th St., Dumas.
Wright, Norman E., (Int.),
4146 Lemac, Houston.

DEAF SMITH-PARMER-CASTRO-OLDHAM-SWISHER

Barnett, Lewis B., Box 986, Hereford.
Bischoff, Harold W., P. O. Box 488, Dimmitt.
Burk, Houston M., 200 N. Austin, Tulia.
Childress, Wm. B.,
118 S. W. 1st St., Tulia.
Cogswell, Ronald E., Dimmitt.
Foreman, Lee S., Tulia.
Grubbs, Roy J., Box 352, Hereford.
Loyd, Oscar H., (Hon.), Vega.
McDowell, Ansel L., Jr., Box 863, Friona.
Mims, Arthur T., Hereford.
Nobles, Millard W.,
111 N. Knight St., Hereford.
Page, Carl F., Box 188, Dimmitt.
Richards, Fred V., (Sec'y.), Tulia.
Sisley, Nina Mae, 343 Miles Ave., Hereford.
Spence, Joseph W., Jr., Box 188, Dimmitt.
Spring, Floyd Lee, Friona.
Spring, Paul L., Friona.
Stewart, Evans P., (Pres.), Tulia.
Wills, Ralph R., Hereford.

GRAY-HANSFORD-HEMPHILL-LIPSCOMB-ROBERTS-OCHILTREE-HUTCHINSON-CARSON

Ashby, Charles H.,
1701 N. Hobart St., Pampa.
Barksdale, William C.,
510 N. Weatherly, Borger.
Bellamy, Russell M.,
Combs Worley Bldg., Pampa.
Blaisdell, Glenn D., 301 Davis, Spearman.
Brindley, Claunch G.,
1063 Coronado Circle, Borger.
Brown, R. Malcolm, Florida & Hobart, Pampa.
Donaldson, Joe R., Hughes Bldg., Pampa.
Elder, John F., (Pres.),
600 W. Kentucky, Pampa.
Ellis, Neely Joe, (Sec'y.),
Combs Worley Bldg., Pampa.
Fabian, Harold F., Box Q, McLean.
Falkenstein, Richard D.,
600 W. Kentucky, Pampa.
Gates, Joseph W., P. O. Box 1421, Pampa.
Gates, Philip A., Box 1421, Pampa.
Hampton, Dan E., 207 S. McGee, Borger.
Hampton, Raymond M.,
M and S Clinic, Pampa.
Hamra, Henry M.,
1008 Megert Shopping Center, Borger.
Hays, Harvey, Jr.,
412 South Main St., Borger.
High, Clifton E., Box 1701, Pampa.
Hollingsworth, H. W.,
Phillips Med. Center, Phillips.
Holmes, Robert L., Jr.,
Phillips Med. Center, Phillips.
Hrdlicka, George R.,
300 Hughes Bldg., Pampa.
Ingham, Mahlon E., 500 W. 3rd, Borger.
Johnson, J. Bluford,
Sanford Clinic Hosp., Perryton.
Jones, W. Calvin, 312 Rose Bldg., Pampa.
Kelley, Frank W., 516 W. Kentucky, Pampa.
Kengle, George L., Perryton.
Key, Julian M., Box 1782, Pampa.
Kimball, Melvin C., 501 Butadieno, Borger.
Kleeberger, Roland L., Box 545, Spearman.
Knowles, Joe H.,
1063 Coronado Circle, Borger.
Lang, Carl M., Hughes Bldg., Pampa.
Laycock, Raymond W.,
516 W. Kentucky, Pampa.
Massad, Woodrow W.,
1008 Megert Shopping Center, Borger.
McDaniel, MacField, Box 1782, Pampa.
Monroe, Carroll D., 514 S. Main, Perryton.
Moore, Robert W., 1818 Chestnut St., Pampa.
Morris, Ernest H., Canadian.
Overton, Marvin C., Jr., Hughes Bldg., Pampa.
Parker, William L., Box 717, Perryton.
Pearson, Daniel B., Jr., Perryton.
Prewit, Rex D., 500 W. Third St., Borger.
Purviance, Walter, (Hon.),
Box 1357, Pampa.
Sanford, Roy K., Perryton.
Scott, Gordon W., 300 Hughes Bldg., Pampa.
Snyder, Rush A., 405 Main St., Canadian.
Stephens, Milton M., 412 S. Main, Borger.
Stephens, Walton G., 412 S. Main, Borger.
Vendrell, Felix J., Pampa Clinic, Pampa.
Voet, Henriette H.,
114 W. Grand Ave., Borger.
Williams, Edward S.,
300 Hughes Bldg., Pampa.

HALE-FLOYD-BRISCOE

Benzon, George H., III, (Sec'y.)
801 West 8th St., Plainview.
Bublis, Mary E., 1001 W. Ninth, Plainview.
Bublis, Norbert J., 801 West 8th, Plainview.
Crum, Kenneth O., Lockney.
Davis, Jeff H., 220 St. Louis, Plainview.
Dils, Grover C., Caliente, Nevada.
Dye, Mary R., 312 Skaggs Bldg., Plainview.
Foster, Dee R., Box 245, Hale Center.
Freeman, Ray W., Hale Center.
Hansen, J. Harvey, 801 W. 8th St., Plainview.
Harvis, Herman J., 708 Denver, Plainview.
Heye, Randall G.,
801-813 W. 8th St., Plainview.
Hill, Clarence T., Jr.,
801 W. 8th St., Plainview.
Horn, Joe J., Box 391, Plainview.
Howell, McKinley,
214 Skaggs Bldg., Plainview.
Jackson, Carl C., 706 Denver St., Plainview.
Johnson, Gilmer B., Jr.,
211 Skaggs Bldg., Plainview.
Long, Dorothy C., Skaggs Bldg., Plainview.
Long, John C., 801 W. 8th, Plainview.
Mangold, William J.,
Lockney Gen. Hosp., Lockney.
McCarthy, Eugene C.,
220 St. Louis, Plainview.
McClelland, Gene A., (Int.)
2812 Yates, Fort Worth
Mitchell, Robert H.,
204 Skaggs Bldg., Plainview.
Nichols, E. O., Jr.,
215 W. Alpine, Plainview.
Nichols, E. O., Sr.,
1402 W. Eleventh St., Plainview.
O'Grady, Joseph A.,
715 Houston St., Plainview.
Roberts, Roy R.,
801-813 W. 8th St., Plainview.
Schlecte, Marvin C., 714 W. 7th, Plainview.
Smith, Landria C.,
217 Skaggs Bldg., Plainview.
Snyderman, Henry,
Plainview Hosp., Plainview.
Thomas, W. Ralph, 220 St. Louis, Plainview.
Wagner, Gerald W.,
321 Skaggs Bldg., Plainview.
Wayland, Levi C., (Hon.),
Room 3, Skaggs Bldg., Plainview.
Williams, Pat, Lockney Gen. Hosp., Lockney.
Williams, Russell K., (Pres.),
805 W. 8th St., Plainview.

HARDEMAN-COTTLE-FOARD-MOTLEY

Brooks, Walter A., (Pres.),
404 Mercer St., Quanah.
George, Joseph M., Quanah.
Harmon, Franklin C., Jr., Paducah.
Hughes, John F., Spur.
McDaniel, Robert R., Quanah.
Pate, Clarence C., Paducah.
Salkeld, Phil L., Quanah.
Sitta, Raymond E., Chillicothe.
Stanley, James S., Matador.
Taylor, John M., (Sec'y.),
404 Mercer St., Quanah.
Traweek, Albert C., Matador.
Traweek, Albert C., Jr.,
P. O. Box 296, Matador.

LAMB-BAILEY-HOCKLEY-COCHRAN

Barnes, Elbert D.,
1212 Houston St., Levelland.
Brown, Dan M., 210 S. W. 2nd St., Morton.
Campbell, Dale P., (Sec'y.),
409 Austin, Levelland.
Dillen, William A.,
Med. Arts Clinic-Hosp., Littlefield.
Dupre, John D., 1212 Houston, Levelland.
Edgar, George V.,
1209-B Houston St., Levelland.
Fain, J. Randel,
500 Littlefield Dr., Littlefield.
Faust, Fredric B., Faust Clinic & Lab., Earth.
Green, Lathaggar, Jr., Box 368, Muleshoe.
Holder, John B., Box 967, Littlefield.
Janes, Fred W., Littlefield.
Lee, Billie H., 200 E. Grant Ave., Morton.
Maurer, Ralph E.,
500 Littlefield Dr., Littlefield.
Nowlin, William C.,
Littlefield Clinic, Littlefield.
Phillips, Claurice M.,
1212 Houston, Levelland.
Reid, Raymond A., (Pres.),
Phillips-Dupre Hosp., Levelland.
Renegar, James G., 611 Ave. D, Levelland.
Shotwell, Ira T., Jr., Littlefield.
Stafford, Delmon J.,
401 W. 6th St., Littlefield.
Still, Oscar W., Littlefield.
Walsh, Andrew L., 611 Ave. D, Levelland.

LUBBOCK-CROSBY

Adams, Erie Dell, 1910 Knoxville, Lubbock.
Anderson, William F.,
1312 Main St., Lubbock.
Ansley, Leslie R., 2615 19th St., Lubbock.
Arnett, Sam C., Jr., 2609 19th St., Lubbock.
Arnold, Robert N., 1910 Knoxville, Lubbock.
Barsh, Albert G., 2010 Broadway, Lubbock.
Batson, Carey B., 1315 Tenth St., Lubbock.
Baugh, William L., (Hon.),
1302 Main St., Lubbock.
Bertinot, C. Walter,
3621 21st St., Lubbock.
Birdsong, William F., Muleshoe.
Black, Crawford H.,
505 N. Weatherly, Borger.
Blake, Emerson M., 1910 Knoxville, Lubbock.
Boling, John S., 1910 Knoxville, Lubbock.
Bronwell, Alvin W., (Pres.),
1910 Knoxville, Lubbock.
Canon, Robert T., 1312 Main St., Lubbock.
Carnrick, Millard, Jr.,
701 College Ave., Lubbock.
Carr, Robert L., 2602 Avenue Q, Lubbock.
Cashion, William R.,
2010 Broadway, Lubbock.
Chalk, John R., 802 Avenue N, Lubbock.
Chatman, Joseph A., 2303 Cedar, Lubbock.
Clark, Doyce M.,
1910 Knoxville Ave., Lubbock.
Clark, Vester V., (Hon.),
4716 22nd St., Lubbock.
Cobb, John L., 4412 W. 17th St., Lubbock.
Cole, Richard D., 1910 Knoxville, Lubbock.
Croom, William S., 1910 Knoxville, Lubbock.
Cross, Denzil D., (Inac.),
1312 Main St., Lubbock.
Curtis, Harrison E., 1910 Knoxville, Lubbock.
Daniel, Arthur L., 2613 34th St., Lubbock.
DeLaney, Robert M., Abernathy.
Donaldson, J. D., Jr.,
3213 42nd St., Lubbock.
Douglas, Richard C., 1318 Main St., Lubbock.
Dunn, Jack, Jr., 1910 Knoxville, Lubbock.
Dunn, Sam G., 1312 Main St., Lubbock.
Duran C, Armando, Box 601, Lubbock.
Elkins, Clyde F., Jr., 1626 15th St., Lubbock.
Ellis, Noel A., 2602 Avenue Q, Lubbock.
English, Otis W., 1312 Main St., Lubbock.
Evans, William G., 1910 Knoxville, Lubbock.
Ewing, Mahon M., 2609 19th St., Lubbock.
Fiel, Charles A., 3701 19th St., Lubbock.
Forsythe, Ted H., 3820 32nd St., Lubbock.
Goodwin, Frank C.,
701 College Ave., Lubbock.
Gordon, William H.,
2022 Broadway, Lubbock.
Hale, Lee E., 802 Avenue N, Lubbock.
Hall, James T., 511 College Ave., Lubbock.
Hancock, Howard R.,
2615 19th St., Lubbock.
Hand, Orra Robert, 1910 Knoxville, Lubbock.
Haney, Edward L., (Inac.), Ralls.
Harris, Joseph R., Jr., 1211 Ave. O, Lubbock.
Healy, Maurice J., 1910 Knoxville, Lubbock.
Hendon, Robert G., Jr.,
1910 Knoxville, Lubbock.
Hess, Wallace I., 3201 42nd St., Lubbock.
Hewitt, Archie Lee, 1910 Knoxville, Lubbock.
Holmes, T. H., Jr., Jeff Davis Hosp., Houston.
Holt, William D., 2352 34th St., Lubbock.
Houser, O. Wayne, (Mil.),
Box 356, Crosbyton.
Hudgins, Frank W.,
1910 Knoxville, Lubbock.
Hull, O. Brandon, 2022 Broadway, Lubbock.
Hunt, Ewell L., 1312 Main St., Lubbock.
Hutchinson, Ben B., 1647 Broadway, Lubbock.
Isham, Asa C., 1910 Knoxville, Lubbock.
Jaynes, Stan H., 825 W. Lubbock St., Slaton.
Jenkins, B. Arthur, 1910 Knoxville, Lubbock.
Jones, Elmer W., (Hon.),
3415 20th St., Lubbock.
Jones, Glenn M., 3615 19th St., Lubbock.
Kallina, Frederick P.,
Tech Infirmary, Lubbock.
Keffler, Richard A., 3615 19th St., Lubbock.
Key, Olan, 2609 19th St., Lubbock.
Krueger, Julius T., 1910 Knoxville, Lubbock.
Lane, Ralph, 1312 Main St., Lubbock.
Lewis, Richard Q., 3060 34th St., Lubbock.
Lewis, Royce C., Jr.,
1910 Knoxville, Lubbock.
Locke, John C., P. O. Box 456, Slaton.

Loveless, J. Elbert, 2425 7th St., Lubbock.
Loveless, Roy G., 2609 19th St., Lubbock.
Lovings, Franklin L., 2609 Hickory, Lubbock.
Lunceford, Tennie Mae,
1301 Broadway, Lubbock.
Malone, Frank B., 2609 19th St., Lubbock.
Mansell, Chris C., 1302 Main St., Lubbock.
Mantooth, Walter B., Jr.,
2615 19th St., Lubbock.
Marable, Gerald L.,
3414-B Avenue H, Lubbock.
Mattison, Myron D., 3621 21st St., Lubbock.
Mayfield, Ivan G., 1318 Main, Lubbock.
McCarty, Robert H.,
1910 Knoxville, Lubbock.
McClure, Edwin E.,
701 College Ave., Lubbock.
McDaniel, Bennie O., Muleshoe.
McSween, M. Jay, Jr.,
123 W. Lubbock, Slaton.
Melton, William H.,
1328 Cincinnati, El Paso.
Miller, John T., Jr.,
Great Plains Bldg., Lubbock.
Miller, Pauline A., 2609 19th St., Lubbock.
Monk, Norman A.,
511 College Drive, Lubbock.
Monte, Melville R.,
5117 Lubbock Ave., Fort Worth.
Montgomery, Clifford L.,
3615 21st St., Lubbock.
Moore, Robert, 1211 Avenue O, Lubbock.
Morris, James G. (Sec'y.),
1312 Main St., Lubbock.
Moss, Charles B., 1318 Main St., Lubbock.
Moss, Ennis E.,
Methodist Med. Bldg., Lubbock.
Nalle, Ernest, Jr., 1312 Main St., Lubbock.
Nash, Charles H., Jr.,
1910 Knoxville, Lubbock.
Nemir, Stuart S., Jr., 3615 21st St., Lubbock.
O'Loughlin, Richard K.,
1910 Knoxville, Lubbock.
Parker, Thomas G.,
23 Baldwin Ave., San Mateo, Calif.
Parsons, James M., 1318 Main St., Lubbock.
Payne, Clifford E., 2415 6th St., Lubbock.
Payne, Glen B., 250 W. Lubbock, Slaton.
Pennington, Hugh A.,
2613 34th St., Lubbock.
Poole, Warren B., 3060 34th St., Lubbock.
Porres, Felipe D., 4906 17th St., Lubbock.
Porres, Norma E., 118 Jarvis, Lubbock.
Ratcliff, Charles E., 1910 Knoxville, Lubbock.
Reinke, R. Thomas, 3615 19th St., Lubbock.
Rhoades, Dale R., Crosbyton.
Riddel, Roy L., Jr., 1318 Main St., Lubbock.
Rountree, John B., Jr.,
2615 19th St., Lubbock.
Rutledge, Randolph,
1910 Knoxville, Lubbock.
Ryburn, Frank M., Jr.,
3621 21st St., Lubbock.
Selby, John H., 1910 Knoxville, Lubbock.
Shannon, Emmet, 1910 Knoxville, Lubbock.
Shepard, Herbert L.,
Med. Arts Clinic, Lubbock.
Slemmons, Theodore M., Muleshoe.
Smith, Jerome A., (Int.),
Great Plains Bldg., Lubbock.
Smith, Lynwood B., 1910 Knoxville, Lubbock.
Smith, Roy L., 1910 Knoxville, Lubbock.
Smith, William C., 1910 Knoxville, Lubbock.
Snodgrass, Milo R., Crosbyton.
Snow, Wister C., (Inac.),
3315 39th St., Lubbock.
Spikes, Lowell W., Ralls.
Stewart, Allen T., 1318 Main St., Lubbock.
Stiles, James Hooper,
1910 Knoxville, Lubbock.
Storrs, Loyd A., 1910 Knoxville, Lubbock.
Stout, Ruth Louise, 2352 34th St., Lubbock.
Surman, Arnold C., (Hon.), Post.
Talbert, Thomas L., 123 W. Lubbock, Slaton.
Taylor, Otis, Jr., 511 College, Lubbock.
Tubbs, Harry A., Post.
Ullom, William S., 4122 34th St., Lubbock.
Upshaw, Leon R., 1312 Main St., Lubbock.
Wallace, Grady M., 1647 Broadway, Lubbock.
Warshaw, Harold, 1910 Knoxville, Lubbock.
Watkins, Mina D., 1312 Main St., Lubbock.
Williams, David C., (Hon.), Post.
Woods, Limmie B., (Inac.),
2402 Main St., Lubbock.
Yarbrough, Ocie Carl, 4224 Boston, Lubbock.

POTTER-RANDALL

Archer, John R., 2603 Henning, Amarillo.
Aronson, Sam J. R., 1422 Tyler, Amarillo.
Askew, Wesley L., Jr., 1422 Tyler, Amarillo.
Blackwell, Ben T., 705 Fisk Bldg., Amarillo.
Bordelon, Howard M.,
2204 W. 6th Ave., Amarillo.
Boswell, Leta N., Canyon.
Bryan, E. Kay, 819 Martin Road, Amarillo.
Bryan, J. Manly, 608 16th St., Canyon.
Budd, Robert G., P. O. Box 7087, Amarillo.
Budd, Wilbur Q., 802 Rusk, Amarillo.
Campbell, Robert E.,
2004 NW 19th, Oklahoma City, Okla.
Campbell, William J.,
1422 Tyler St., Amarillo.
Carroll, J. Ralph, 702 Harrison St., Amarillo.
Chase, Gaylord R., 1422 Tyler St., Amarillo.
Chastain, Richard L.,
1608 Madison, Amarillo.
Churchill, T. Preston, Box 710, Amarillo.
Citron, Ralph, 2206 West 6th St., Amarillo.
Cole, Marion W., VA Hosp., Amarillo.
Crume, John J., (Hon.),
Herring Hotel, Amarillo.
Crumley, Fred J., 916 Fisk Bldg., Amarillo.
Daugherty, Roy,
4002 S. Washington, Amarillo.
Davis, Frances E., 814 Lamar, Amarillo.
Davis, Margaret M., 814 Lamar St., Amarillo.
Denko, John V., Box 1110, Amarillo.
Dine, William C., 1422 Tyler St., Amarillo.
Dravin, Isadore, 1422 Tyler St., Amarillo.
Duke, Tom W., 1422 Tyler St., Amarillo.
Duncan, Frank B.,
339 Amarillo Bldg., Amarillo.
Duncan, Robert A.,
339 Amarillo Bldg., Amarillo.
Ellis, J. Victor, 315 Fisk Bldg., Amarillo.
Flamm, Kenneth R.,
205 Amarillo Bldg., Amarillo.
Gallagher, Robert P., (Hon.),
4201 Bonham, Amarillo.
Garre, Peter R., 1422 Tyler St., Amarillo.
Gilkerson, Nan L., (Inac.),
Fisk Bldg., Amarillo.
Glenn, William A.,
P. O. Box 3134, Amarillo.
Goldston, Alton B.,
1501 W. 10th St., Amarillo.
Greer, Rex E., 412 Barfield Bldg., Amarillo.
Haralson, Prescott H.,
1817 Washington,, Amarillo.
Harkleroad, Frank S., 616 N. Polk, Amarillo.
Hatchett, Capres S., (Pres.),
800 Rusk St., Amarillo.
Hegedus, William J.,
2714 W. 10th St., Amarillo.
Hyde, Robert F., 2714 W. 10th St., Amarillo.
Intress, Robert H.,
2223 Hughes St., Amarillo.
Jackson, Harvey K.,
506 Georgia St., Amarillo.
Jacobson, Merlin E.,
V. A. Hosp., Wichita, Kan.
Jarrett, Robert P., Canyon.
Johnson, H. Fred,
2308 W. 8th St., Amarillo.
Johnson, James L., 1422 Tyler St., Amarillo.
Johnson, Jere B.,
1501 W. 10th St., Amarillo.
Johnson, L. G., 3604 S. Hayden, Amarillo.
Jones, Billy Rual, 814 Lamar, Amarillo.
Jones, Elmer K., 604 W. 8th Ave., Amarillo.
Jordaan, John D., Box 1411, Amarillo.
Kelly, Francis J., 810 Bryan St., Amarillo.
Klingensmith, Wm., Jr.,
708 Monroe, Amarillo.
Klingensmith, Wm. R., (Inac.)
1413 Lipscomb, Amarillo.
Latson, Harvey H.,
324 Amarillo Bldg., Amarillo.
Laur, William E., 608 W. 8th, Amarillo.
Lemmon, J. Ralph,
2714 West 10th Ave., Amarillo.
Lipscomb, Joe L., 2414 W. 9th, Amarillo.
Lokey, Early B., 719 Austin, Amarillo.
Loving, Dan H., 611 Fisk Bldg., Amarillo.
Marsalis, Don S., 1422 Tyler, Amarillo.
Masters, Bert A.,
716 West 18th St., Amarillo.
McKay, Edward D., 812 Fisk Bldg., Amarillo.
Mears, Edward J.,
1501 W. 10th St., Amarillo.
Mok, Wa T., 2710 West 10th St., Amarillo.
Moore, G. Dudley, Jr., Box 35, Canyon.
Mullins, William B.,
2308 W. 8th St., Amarillo.
Murphy, Weldon O.,
812 Fisk Bldg., Amarillo.
Naslund, Edward G.,
1217 West 10th, Amarillo.
Neblett, Robert A.,
Neblett Hosp. & Clinic, Canyon.
Nester, Chas. R., Canyon.
Oles, C. Patrick (Int.),
Parkland Hospital, Dallas.
Owens, Guy, Amarillo Bldg., Amarillo.
Patton, David M., 703 Harrison St., Amarillo.
Patton, Louis K., 703 Harrison St., Amarillo.
Payne, Ralph B., 608 W. 8th St., Amarillo.
Pickett, John M.,
2714 West 10th Ave., Amarillo.
Potter,, Wilkes A., 2007 West 7th, Amarillo.
Powers, Evelyn G., Fisk Bldg., Amarillo.
Powers, George L., Fisk Bldg., Amarillo.
Price, William T., Jr.,
1422 S. Tyler, Amarillo.
Pronko, Michael J.,
2710 W. 10th Ave., Amarillo.
Puckett, Howard E.,
205 Amarillo Bldg., Amarillo.
Reed, Holley W., (Sec'y.),
2414 W. 9th, Amarillo.
Reid, Howard C., 315 Fisk Bldg., Amarillo.
Robberson, Jason H.,
1422 S. Tyler, Amarillo.
Robberson, Joe Frank, (Int.),
9941 Bassoon, Houston.
Rook, Rex L., 719 Austin, Amarillo.
Rowley, Elmer A.,
205 Amarillo Bldg., Amarillo.
Royse, George T., 603 Fisk Bldg., Amarillo.
Russell, Woolworth, 2710 W. 10th, Amarillo.
Sadler, Charles B.,
915 W. 8th Ave., Amarillo.
Scott, T. G., St. Anthonys Hosp., Amarillo.
Scott, Wilbert E., 706 Monroe St., Amarillo.
Smith, G. Ernestine,
814 Lamar St., Amarillo.
Stout, William W., 703 Harrison, Amarillo.
Streit, August J., Fisk Bldg., Amarillo.
Swindell, Raymon R.,
2400 Line Ave., Amarillo.
Thomas, Edward F., 600 W. 8th, Amarillo.
Van Sweringen, Walter,
231 Amarillo Bldg., Amarillo.
Vaughan, John H.,
1607 Van Buren, Amarillo.
Vineyard, Roy L., 1801 Harrison, Amarillo.
Vinyard, George T. (Hon.),
Box 1385, Amarillo.
Waddill, George M., Jr.,
2308 W. 8th, Amarillo.
Walkes, Ernest E., V. A. Hosp., Amarillo.
Watkins, Walter C., 606 W. 8th, Amarillo.
Werner, Jan R., 2307 W. 7th, Amarillo.
Wertz, Royal F., 800 Rusk St.; Amarillo.
Wheir, William H.,
2400 Line Ave., Amarillo.
White, Jesse B., 518 Amarillo Bldg., Amarillo
Winsett, Amos E., 611 Fisk Bldg., Amarillo.
Winsett, E. Merrill, 611 Fisk Bldg., Amarillo.
Witcher, Jones E., 2300 Line Ave., Amarillo.
Witt, John E., (Int.),
Kern Gen. Hosp., Bakersfield, Calif.
Wolf, Horace L., P. O. Box 2068, Amarillo.
Wolfson, Charles, 2718 W. 10th, Amarillo.
Wyatt, George W., 1422 Tyler St., Amarillo.
Wyatt, James Odis, (Dead).
Yeakel, S. Victor, 2400 Line Ave., Amarillo.

FOURTH DISTRICT

Dr. O. H. Chandler, Ballinger, Councilor

BROWN-COMANCHE-MILLS-SAN SABA

Bowden, A. M., (Hon.), May.
Bullard, Chester C., (Hon.),
1616 Austin Ave., Brownwood.
Cadenhead, Ernest F.,
2401 Coggin Ave., Brownwood.
Childress, Marvin A., Goldthwaite.
Farley, Frederick W., San Saba.
Felts, Richard C., San Saba.
Galbreath, John C., Brownwood.
Gold, Philip S., (Pres.), Brownwood.
Gray, Charles W., (Hon.), Comanche.
Hallum, Roy G.,
409 E. Adams St., Brownwood.
Hames, Frederick W.,
1505 Eleventh St., Brownwood.
Hughes, Sidney W.,
Citizens Natl. Bk. Bldg., Brownwood.
Koch, Herbert E.,
214 West Grand, Comanche.
Lobstein, Henry L.,
1319 Austin Ave., Brownwood.
Locker, Harry L., Route 3, Brownwood.
Locker, S. Braswell,
1501 11th St., Brownwood.
Mayo, Oscar N., Box 790, Brownwood.
McFarlane, Joe R.,
Citizens Bank Bldg., Brownwood.
McGowan, Patrick T.,
Med. Arts Clinic, Brownwood.

Nyvall, Harry O.,
Smith Mem. Hosp., Gustine.
Ory, Lee K., (Sec'y), Comanche.
Pence, Winfield S., San Saba.
Pope, Fielding M.,
501 Citizens Natl. Bk. Bldg., Brownwood.
Snyder, Ned, Jr.,
Coggin at 12th, Brownwood.
Spencer, Fred D., Jr.,
308 West Chandler, Brownwood.
Stephens, Joe B., Bangs.
Sweet, William O.,
Citizens Natl. Bk. Bldg., Brownwood.
Walker, James B. N., Brownwood.
Wheelis, Paul M.,
Medical Arts Bldg., Brownwood.

COLEMAN

Aston, S. N., (Hon.), Coleman.
Bailey, Robert, (Hon.), Coleman.
Burke, Francis M., 309 S. Pecos, Coleman.
Duke, Jean D., 208 W. College, Coleman.
Jennings, William L., Coleman.
Kemper, R. F.,
Coleman Mutual Bldg., Coleman.
Kollwitz, Fred E., 1400 Fae St., Santa Anna.
Lovelady, Roy R., 309 S. Pecos St., Coleman.
Mann, Morris D., (Sec'y),
301 W. Pecan St., Coleman.
Moody, Charles O.,
301 W. Pecan St., Coleman.
Weaver, Manly E.,
Coleman Co. Bk. Bldg., Coleman.
Yarbrough, Cecil G.,
V. A. Hospital, Hines, Ill.
Young, Josephus C., (Pres.),
205 W. Elm, Coleman.

CRANE-UPTON-REAGAN

Cooper, James L., McCamey.
Gossett, James D., Rankin.
Maynard, Billy J., Box 1145, Crane.
Nibling, Boyd, Box 1178, McCamey.
Terry, John E., (Sec'y), Box 1145, Crane.
Wright, John L., Jr., Box 847, Big Lake.

KIMBLE-MASON-MENARD-McCULLOCH

Anderson, James P., Brady.
Anderson, James S., Brady.
Baze, Perry A., (Hon.), Mason.
Bodenhamer, James G., Mason.
Hallum, B. A., Jr., (Sec'y), Brady.
Hanus, Joseph J., Austin State Hosp., Austin.
Hartgraves, Hallie, (Hon.),
Kemper Hall, Kenosha, Wisc.
Hays, Aaron R., (Hon.), Brady.
Hays, Robert D., Brady.
Hinchman, Alda W., Brady.
Jordan, Dowdell W., Brady.
Land, Wm. M., (Hon.), Lohn.
McCall, John G., (Hon.), Brady.
McCulloh, Albert M., Brady.
Ricks, Glenn H., Brady.

RUNNELS

Bailey, Charles F., (Sec'y), Ballinger
Chandler, Oren H., Ballinger.
Dixon, James W., (Hon.), Box 30, Winters.
Downing, Lloyd L.,
1120 W. Cedar St., Cherokee, Iowa.
Green, John E., Jr., Ballinger.
Jennings, Thomas V., (Hon.), Winters.
McCreight, Henry H., (Pres.),
Box R, Winters.
Rives, C. T., Winters.
Shiller, John J., Rowena.

TOM GREEN-COKE-CROCKETT-CONCHO-IRION-STERLING-SUTTON-SCHLEICHER

Adams, M. Dean, Box 395, Bronte.
Alexander, Eugene P.,
2021 W. Beauregard, San Angelo.
Allison, Richard F.,
McKnight State San., Sanatorium.
Anderson, Hiram M.,
224 E. Harris, San Angelo.
Anderson, Wilson D.,
123 W. Harris, San Angelo.
Arledge, Robert M.,
203 E. Harris, San Angelo.
Ballard, John E.,
Shannon Mem. Hosp., San Angelo.
Barry Douglas J.,
115 E. Beauregard, San Angelo.
Bolen, John G.,
Med. Arts Bldg., San Angelo.
Boster, Raymond G.,
219 S. Magdalen, San Angelo.
Brask, H. Kermit,
1411 Shafter, San Angelo.
Brauns, Wilhelm H.,
234 W. Beauregard, San Angelo.
Browne, Charles F., Sonora.
Bunyard, Joseph A.,
S. A. Natl. Bk. Bldg., San Angelo.
Burgess, George A.,
248 Jefferson St., Eagle Pass.
Butner, Wendell B.,
Med. Arts Bldg., San Angelo.
Byars, Perry J. C., Jr.,
Med. Arts Bldg., San Angelo.
Carter, John E., Eden.
Chase, Ralph R., Jr.,
234 W. Beauregard, San Angelo.
Cohen, Milton R., P. O. Box 53, San Angelo.
Coleman, T. Gabe, (Mil.),
510 W. Beauregard, San Angelo.
Cornelison, Joe L.,
510 W. Beauregard, San Angelo.
Eckhardt, Gus F.,
510 W. Beauregard, San Angelo.
Engelking, Chas. F.,
234 W. Beauregard, San Angelo.
Everhart, Merrill W.,
2704 Douglas Dr., San Angelo.
Finks, Robert M., Clinic Hospital, San Angelo.
Franken, Robert,
408 Chadbourne Bldg., San Angelo.
French, Cecil M., 339 W. Harris, San Angelo.
Gainer, Marthalyn J.,
612 E. Parkway, San Angelo.
Gainer, Sam H., Med. Arts Bldg., San Angelo.
Gaspar, Geza, 9 S. Magdalen, San Angelo.
Harris, John R., Bronte.
Harris, Orion W., P. O. Box 483, Sanatorium.
Hayter, Dale W.,
234 W. Beauregard, San Angelo.
Hershberger, Lloyd R.,
Med. Arts Bldg., San Angelo.
Hollister, W. L., (Inac.),
202 E. Ave. J, San Angelo.
Hooker, James W.,
510 W. Beauregard, San Angelo.
Howell, John F., Sonora.
Hunter, Darlene L.,
2719 Live Oak, San Angelo.
Hunter, Thos. R., Jr.,
234 W. Beauregard, San Angelo.
Hutchins, F. Leon,
Med. Arts Bldg., San Angelo.
Irvine, Geo. N., Jr.,
510 W. Beauregard, San Angelo.
Johnson, Clay H.,
205 E. Beauregard, San Angelo.
Joiner, Bennett A., 111 E. Harris, San Angelo.
Jones, Robert R.,
2015 W. Beauregard, San Angelo.
Kilman, William J.,
McKnight San., Sanatorium.
Knight, Maynard D.,
234 W. Beauregard, San Angelo.
Kunath, Carl A., 111 E. Harris, San Angelo.
Landy, Aaron E., 14 S. Jefferson, San Angelo.
Lewis, Aubrey L.,
123 E. Beauregard, San Angelo.
Martin, Scott H., 115 S. Park, San Angelo.
McCaw, Blanche M.,
444 Preusser, San Angelo.
McCaw, William H.,
111 East Harris, San Angelo.
McDaniel, John D., Robert Lee.
McIntire, Floyd T., Box 1472, San Angelo.
McKnight, Joseph B., (Hon.),
2206 Dallas St., San Angelo.
Mee, Edmond L., 224 E. Harris, San Angelo.
Moon, Roy E.,
234 W. Beauregard, San Angelo.
Morse, Robert A., (Sec'y),
234 W. Beauregard, San Angelo.
Mowrey, Jack I., Box 548, Eldorado.
Nesrsta, George L.,
111 E. Harris, San Angelo.
Nibling, George W., (Hon.),
1416 W. Harris, San Angelo.
Peyton, Alton B.,
2465 S. Downing St., Denver, Colo.
Pilmer, Gordon A.,
Med. Arts Bldg., San Angelo.
Porter, William L., 111 E. Harris, San Angelo.
Powers, Rufus L., 203 E. Harris, San Angelo.
Rape, J. Marvin, 22 S. Magdalen, San Angelo.
Read, John L.,
2017 W. Beauregard, San Angelo.
Reilly, Daniel R., City Hall, San Angelo.
Ricci, Henry N., 602 S. Abe, San Angelo.
Round, Harry F., 201 E. Harris, San Angelo.
Round, Kye B., (Pres.),
201 E. Harris, San Angelo.
Rush, Clyde E., 2021 Pecos, San Angelo.
Schulkey, William E., (Hon.),
1221 S. Madison, San Angelo.
Schulze, Victor E.,
219 S. Magdalen, San Angelo.
Sessums, J. Valton,
635 S. Bishop St., San Angelo.
Sessums, John R., (Hon.),
1324 W. Ave. D, San Angelo.
Sherrill, Lloyd H., Ozona.
Simon, Ralph E., Jr., Box 818, Ozona.
Smith, W. Lacey, 111 E. Harris, San Angelo.
Spencer, Francis M.,
111 E. Harris Ave., San Angelo.
Swann, William J., Sterling City.
Tandy, Hugh B., Ozona.
Tester, Lewis K.,
Central Natl. Bk. Bldg., San Angelo.
Thompson, Chase S.,
111 E. Harris, San Angelo.
Trotter, Raleigh F.,
9 S. Magdalen, San Angelo.
Wall, D. D., 234 W. Beauregard, San Angelo.
White, James N., 206 E. Harris, San Angelo.
Williams, Harvey M.,
Med. Arts Bldg., San Angelo.
Windham, Robert E., (Hon.),
Christoval Road, San Angelo.
Womack, Clifford T.,
Med. Arts Bldg., San Angelo.
Womack, William T., (Mil.),
7306 Gerris S. E., Albuquerque, N. Mex.
Wood, Marion L., 224 E. Harris, San Angelo.

FIFTH DISTRICT

Dr. Walter Walthall, San Antonio, Councilor

ATASCOSA

Austin, John D., (Sec'y), Box 98, Pleasanton.
Faggard, John M., Poteet.
Joyce, Walter H., Lytle.
Logan, Ben Merl, Box 306, Jourdanton.
Mann, Robert E., P. O. Box 538, Pleasanton.
Ogden, U. B., (Pres.), Box 568, Pleasanton.
Parker, Milton F., P. O. Box 306, Jourdanton.
Ward, Jeremiah, (Hon.), Poteet.

BEXAR

Adelman, Jack A.,
621 Med. Prof. Bldg., San Antonio.
Aderhold, James P.,
1116 Med. Arts Bldg., San Antonio.
Adler, Harry F.,
1510 Pleasanton Rd., San Antonio.
Aijian, Karl M.,
738 W. French Place, San Antonio.
Alanis, Artemio A.,
1110 El Paso St., San Antonio.
Albert, Arnold, 2714 S. Presa St., San Antonio.
Albert, Monroe,
2714 S. Presa St., San Antonio.
Alexander, Charles B.,
1716 Nix Prof. Bldg., San Antonio.
Allen, Sovern W.,
1020 Med. Arts Bldg., San Antonio.
Allin, Frederick A., (Hon.),
Rt. 4, Box 349, Seguin.
Allin, Willis W.,
1109 E. Commerce, San Antonio.
Altgelt, Daniel D.,
1018 S. Texas Bldg., San Antonio.
Altgelt, James E.,
1018 S. Texas Bldg., San Antonio.
Alvelais, Guillermo R.,
318 N. Santa Rosa, San Antonio.
Alvis, Milton E.,
422 Med. Arts Bldg., San Antonio.
Atkinson, Donald T.,
827 Med. Arts Bldg., San Antonio.
Atmar, Robert C.,
205 Camden St., San Antonio.
Avila, Alejandro P.,
310 Crestline Dr. E., San Antonio.
Barnett, John L.,
1206 Nix Prof. Bldg., San Antonio.
Baros, James A.,
807 Gibbs Bldg., San Antonio.
Barton, Julian C.,
909 Nix Prof. Bldg., San Antonio.
Bates, Leroy E., 717 E. Houston, San Antonio.
Bates, Leroy E., Jr., (Int.),
Robt. B. Green Hosp., San Antonio.
Beach, Asa, 205 Camden St, San Antonio.
Beck, Emma, (Inac.), Fredericksburg.
Bedolla, Miguel A.,
706 S. Laredo, San Antonio.
Benavides, Jose M., (Int.),
515 Morales St., San Antonio.

Bennett, Eaton W.,
P. O. Box 1840, San Antonio.
Berchelmann, Adolph, (Inac.),
809 S. Laredo, San Antonio.
Berchelmann, August G.,
200 Donaldson, San Antonio.
Berchelmann, David A.,
809 S. Laredo St., San Antonio.
Berler, James M., (Int.),
Med. Prof. Bldg., San Antonio.
Bernard, George E.,
2911 S. New Braunfels, San Antonio.
Berry, Joe H., 516 Lexington, San Antonio.
Berry, Lloyd E., Jr.,
1100 Austin Hwy., San Antonio.
Biggar, James H., (Hon.),
242 Rockwood St., San Antonio.
Bishop, Elmer W.,
1911 Pleasanton Rd., San Antonio.
Blair, James R., Jr.,
516 Lexington Ave., San Antonio.
Block, William J.,
1111 Nix Prof. Bldg., San Antonio.
Bloom, Bernard H.,
629 Moore Bldg., San Antonio.
Blumer, Max A.,
3886 Beechwood Dr., Pittsburgh, Pa.
Boccelato, Salvador L.,
3304 W. Commerce, San Antonio.
Boehs, Charles J.,
1119 Med. Arts Bldg., San Antonio.
Bohmfalk, John H.,
227 E. Hildebrand, San Antonio.
Bondurant, William W., Jr.,
811 Nix Prof. Bldg., San Antonio.
Bonnet, Edith M.,
210 Med. Prof. Bldg., San Antonio.
Borders, James L., (Mil.),
Kelly AFB, San Antonio.
Borsheim, Raymond S.,
1702 Nix Prof. Bldg., San Antonio.
Bosshardt, Carl E.,
1226 Nix Prof. Bldg., San Antonio.
Botkin, Rolan R., 3721 S. Presa, San Antonio.
Bowen, Robert E., Jr.,
531 Med. Arts Bldg., San Antonio.
Bowen, Robt. E., Sr., (Inac.),
1849 W. Gramercy, San Antonio.
Boyd, G. D., 1411 N. Main St., San Antonio.
Boysen, Arthur E.,
1520 McCullough, San Antonio.
Bracken, Clifford C.,
217 S. Presa St., San Antonio.
Bradley, Roy W.,
120 Med. Prof. Bldg., San Antonio.
Brendel, William B.,
111 Gen. Krueger, San Antonio.
Breuer, Alfred, 525 Richmond, San Antonio.
Brewer, Dorothy, 124 Dallas St., San Antonio.
Britton, Howard A.,
402 Fulton Ave., San Antonio.
Brown, Alexander A., (Hon.),
233 Linda Dr., San Antonio.
Brown, Charles T.,
215 Blue Bonnet Bldg., San Antonio.
Brunner, G. Harmon,
306 Med. Prof. Bldg., San Antonio.
Brunner, Robbie Neeley,
306 Med. Prof. Bldg., San Antonio.
Burg, Edward M.,
805 Maverick Bldg., San Antonio.
Burk, Joseph E.,
3203 San Pedro, San Antonio.
Burk, William E.,
1030 Med. Arts Bldg., San Antonio.
Burleson, John H., (Emer.),
644 Funston, San Antonio.
Burns, Thomas B.,
1717 Nix Prof. Bldg., San Antonio.
Burton, Kenneth G.,
3506 S. New Braunfels, San Antonio.
Bush, Howard M.,
1629 Nix Prof. Bldg., San Antonio.
Buttery, Harold D.,
1031 Nix Prof. Bldg., San Antonio.
Buttery, James M.,
609 Med. Arts Bldg., San Antonio.
Calder, Royall M.,
1203 Med. Arts Bldg., San Antonio.
Callan, John R.,
110 E. Hermosa Dr., San Antonio.
Calvert, Hulon E.,
506 Med. Arts Bldg., San Antonio.
Campbell, Billy Gay,
3721 S. Presa St., San Antonio.
Carter, James W., Jr.,
818 Nix Prof. Bldg., San Antonio.
Case, John B.,
625 Med. Arts Bldg., San Antonio.
Castle, Margaret R.,
545 New Moore Bldg., San Antonio.
Cayo, Edward A.,
923 Med. Arts Bldg., San Antonio.
Cayo, Ernest P., (Inac.),
755 E. Mulberry, San Antonio.
Celaya, Albert, 124 Dallas St., San Antonio.
Celaya, Henry,
1211 Med. Arts Bldg., San Antonio.
Center, William M.,
605 Belknap, San Antonio.
Champion, Albert N.,
1223 Med. Arts Bldg., San Antonio.
Chandler, Jack R.,
915 Med. Arts Bldg., San Antonio.
Chankin, Edgar D.,
525 Richmond, San Antonio.
Childers, Herschel N.,
7407 Broadway Ave., San Antonio.
Childers, Marvin A.,
7407 Broadway, San Antonio.
Christian, Thomas E.,
810 Med. Arts Bldg., San Antonio.
Clark, A. Fletcher, Jr.,
506 Med. Prof. Bldg., San Antonio.
Clark, A. Fletcher, Sr.,
225 Med. Arts Bldg., San Antonio.
Clifton, Collis B.,
303 Maverick Bldg., San Antonio.
Coates, Elmer T.,
401 W. Summit, San Antonio.
Cochran, J. Layton,
1220 Med. Arts Bldg., San Antonio.
Coffman, Graham M.,
625 Med. Arts Bldg., San Antonio.
Coindreau, Albert A.,
1018 W. Hildebrand, San Antonio.
Collins, George P., (Mil.),
3810th USAF Hosp., Maxwell AFB, Ala.
Collins, Vera L., Box 204, Grandfalls.
Conroy, Normabelle H., (Inac.),
307 Wyndale, San Antonio.
Cook, Clara G.,
1008 Rigsby Ave., San Antonio.
Cook, James T., (Mil.),
Griffiss AFB, Rome, N. Y.
Cook, Walter R.,
123 Ogden Lane, San Antonio.
Cooper, Elmer E., 505 Howard, San Antonio.
Cooper, Fred B.,
2001 North Main, San Antonio.
Cooper, Harold N.,
212 W. Laurel, San Antonio.
Cooper, Jean Head,
211 Richmond Ave., San Antonio.
Cooper, Melbourne J.,
211 Richmond Ave., San Antonio.
Copeland, Joseph B.,
1014 Med. Arts Bldg., San Antonio.
Cotham, Christian M.,
414 Med. Arts Bldg., San Antonio.
Couch, Marshall D.,
2504 N. Main, San Antonio.
Cover, Ellen C., (Inac.),
Rt. 6, Box 297, San Antonio.
Cowles, Andrew G., (Hon.),
202 W. Kings Hwy., San Antonio.
Coyle, Edward W.,
1030 Nix Prof. Bldg., San Antonio.
Creamer, Dick O.,
817 S. Texas Bldg., San Antonio.
Crews, Eli Rush,
410 Med. Prof. Bldg., San Antonio.
Curtis, Margaret S.,
310 Med. Prof. Bldg., San Antonio.
Dalkowitz, Marcus B.,
515 Med. Prof. Bldg., San Antonio.
Davis, David F.,
406 N. Main Ave., San Antonio.
Davis, F. Milton,
1502 Nix Prof. Bldg., San Antonio.
Davis, Roy N.,
1419 Nix Prof. Bldg., San Antonio.
Day, Phillip L.,
1108 Nix Prof. Bldg., San Antonio.
DeCoursey, Elbert, (Mil.),
Army Med. Serv. Sch., Ft. Sam Houston.
DeGasperi, Joseph A.,
146 Brandon Dr. W., San Antonio.
DeLeon, John J.,
1418 Nix Bldg., San Antonio.
Del Valle, Antonio F.,
P. O. Box 10067, San Antonio.
Des Rochers, Jean B.,
Box 7206, Hackberry Sta., San Antonio.
Diseker, Thomas H.,
328 Med. Arts Bldg., San Antonio.
Dittman, Charles H.,
411 Med. Arts Bldg., San Antonio.
Dodge, Donald T.,
1216 S. Texas Bldg., San Antonio.
Donaldson, James M., Jr.,
923 Nix Bldg., San Antonio.
Dones, Henry C.,
219 E. Locust St., San Antonio.
Donop, Perry T.,
2020 Alamo Natl. Bank, San Antonio.
Dorbandt, Moss M.,
128 W. Commerce St., San Antonio.
Doyle, John L., (Int.),
103 Southill, San Antonio.
Dreibrodt, Ben A.,
612 New Moore Bldg., San Antonio.
Dreiss, Adolph M.,
319 Mission St., San Antonio.
Dufner, Romie M.,
3721 S. Presa St., San Antonio.
Dumas, Edward D.,
425 Med. Arts Bldg., San Antonio.
Duncan, Everett T.,
1009 S. Texas Bldg., San Antonio.
Dupre, Joseph R.,
2331 Vance Jackson, San Antonio.
Ellington, Jesse C.,
128 W. Commerce St., San Antonio.
Ellis, Sam,
710 Med. Arts Bldg., San Antonio.
Elmendorf, Hugo F., Jr.,
215 Camden, San Antonio.
Estrada, Felipe,
1216 Nix Prof. Bldg., San Antonio.
Estrada, Ramiro P.,
318 N. Santa Rosa, San Antonio.
Ewing, Dwight S., (Mil.),
3380th USAF Hosp., Keesler AFB, Miss.
Fairweather, M. Jeanne, (Int.),
V. A. Hosp., Houston.
Farrell, Elnora Anne,
2819 N. McCullough, San Antonio.
Fein, Bernard T.,
216 Med. Prof. Bldg., San Antonio.
Ferrero, James J.,
205 Camden St., San Antonio.
Fetzer, William J.,
1530 W. Summit, San Antonio.
Finney, James W.,
200 Donaldson, San Antonio.
Finsterwald, James F.,
119 General Krueger, San Antonio.
Fischer, Albert,
611 Med. Prof. Bldg., San Antonio.
Fisher, Rowan E.,
1109 S. Texas Bldg., San Antonio.
Folbre, Thomas W.,
1219 Nix Prof. Bldg., San Antonio.
Franke, Winthrop I.,
2512 Main Ave., San Antonio.
French, Jack A.,
906 Fredericksburg Rd., San Antonio.
Galindo, Desiderio L.,
515 Morales St., San Antonio.
Galloway, Ballard E.,
306 Houston Bldg., San Antonio.
Garnett, Walter L., Paseo Reforma 510,
Mexico 6, D. F., Mex.
Garza, Remberto,
525 Richmond, San Antonio.
Geissler, Wallace H.,
313 Med. Prof. Bldg., San Antonio.
Gerodetti, Orlando F.,
344 Mary Louise Dr., San Antonio.
Giesecke, Carl G., (Mil.),
Off. of Surg. 3rd Co., Fort Hood, Texas.
Glass, Thomas G., Jr., (Int.),
5417 Windswept, Houston.
Goeth, Carl F.,
810 Gibbs Bldg., San Antonio.
Goeth, Richard A., (Hon.),
809 Gibbs Bldg., San Antonio.
Goldzieher, Joseph W.,
1133 Med. Arts Bldg., San Antonio.
Gonzalez, Hesiquio N.,
318 N. Santa Rosa, San Antonio.
Gonzalez, Joaquin B.,
318 N. Santa Rosa, San Antonio.
Goode, John W.,
205 Camden St., San Antonio.
Goodnight, James E.,
1005 Nix Prof. Bldg., San Antonio.
Goodpasture, John E.,
2407 W. Huisache, San Antonio.
Gootee, Hubert George,
2714 S. Presa St., San Antonio.
Gordon, Marie D., (Sec'y),
205 Camden St., San Antonio.
Gordon, Wm. H., Jr.,
205 Camden St., San Antonio.
Gorsuch, Paul L.,
1208 Nix Prof. Bldg., San Antonio.
Gossett, Robert F.,
205 Camden St., San Antonio.
Grant, Harold,
602 W. French Pl., San Antonio.

Grant, Lee B., (Mil.),
Kelly AFB, San Antonio.
Grantham, Edwin S.,
124 Dallas St., San Antonio.
Graves, William E.,
1717 Nix Prof. Bldg., San Antonio.
Gray, Arthur M.,
119 Burkedale, San Antonio.
Greer, Sam J., Jr.,
823 Nix Prof. Bldg., San Antonio.
Gregory, Ernest J., Jr.,
Box 7206, Hackberry Sta., San Antonio.
Griffin, Robert W.,
Nix Prof. Bldg., San Antonio.
Griswold, James A.,
3506 S. New Braunfels, San Antonio.
Grosskreutz, Doris C.,
R. B. Green Mem. Hosp., San Antonio.
Haggard, Charles H.,
1228 Med. Arts Bldg., San Antonio.
Haggard, Frank N.,
1228 Med. Arts Bldg., San Antonio.
Haley, Robert Roscoe,
216 N. Santa Rosa, San Antonio.
Hall, Augustus A.,
222 Med. Prof. Bldg., San Antonio.
Hardy, Robert C.,
1233 Nix Prof. Bldg., San Antonio.
Hargis, W. Huard, Sr.,
205 Camden St., San Antonio.
Harle, Raymond P.,
6936 San Pedro, San Antonio.
Hartman, Albert W., Jr.,
809 Nix Prof. Bldg., San Antonio.
Hartman, Henry C. (Hon.),
1104 Rigsby Ave., San Antonio.
Hartman, Ralph F.,
Rt. 11, Box 34, San Antonio.
Hausman, Robert,
Bexar Co. Court House, San Antonio.
Heaney, John P.,
1608 Nix Bldg., San Antonio.
Hebert, Thomas,
5305 So. Flores, San Antonio.
Heck, William H.,
1021 Nix Prof. Bldg., San Antonio.
Held, Edward C.,
2819 N. McCullough, San Antonio.
Helfer, Lewis M.,
208 Med. Prof. Bldg., San Antonio.
Henning, Garold G.,
107 Tulane Dr., San Antonio.
Henry, Colvern D.,
416 Med. Prof. Bldg., San Antonio.
Henry, Mary M.,
601 Med. Arts Bldg., San Antonio.
Herff, Augustus F., Jr., (Int.),
583 VFW Parkway, Chestnut Hill, Mass.
Herff, Augustus F.,
1606 Nix Prof. Bldg., San Antonio.
Herff, Ferdinand P. (Hon.),
Box 155, San Antonio.
Herff, John B. (Hon.),
105 Wyckham Rise, San Antonio.
Hill, Alfred H.,
1216 S. Texas Bldg., San Antonio.
Hill, Lucius D., Jr.,
327 Med. Arts Bldg., San Antonio.
Hills, William J.,
809 Nix Prof. Bldg., San Antonio.
Hinchey, John J.,
1108 Nix Prof. Bldg., San Antonio.
Hogan, Thomas F., Jr.,
Nix Prof. Bldg., San Antonio.
Hollan, O. Roger,
1110 S. Texas Bldg., San Antonio.
Holshouser, Chas. A.,
310 Med. Arts Bldg., San Antonio.
Hooper, Charles H.,
605 Belknap, San Antonio.
Horner, Bernard G.,
3506 S. New Braunfels, San Antonio.
Hoskins, Henry R.,
514 Med. Arts Bldg., San Antonio.
Howard, David S.,
4119 Fredericksburg Rd., San Antonio.
Howerton, Ernest E.,
201 Med. Prof. Bldg., San Antonio.
Hulse, Charles A.,
636 Moore Bldg., San Antonio.
Hunt, Kent N.,
910 Nix Prof. Bldg., San Antonio.
Huntington, Ione,
519 Med. Prof. Bldg., San Antonio.
Jackson, Dudley, Jr.,
1525 Nix Prof. Bldg., San Antonio.
Jackson, Dudley, Sr.,
1525 Nix Prof. Bldg., San Antonio.
Jackson, L. B.,
1030 Med. Arts Bldg., San Antonio.
Jackson, L. Walford,
1030 Med. Arts Bldg., San Antonio.
Jackson, Martha B. (Inac.)
1704 McCall Road, Austin.
Jacob, Norman H.,
120 W. Elsmere, San Antonio.
Jacobs, Milton S.,
510 Med. Prof. Bldg., San Antonio.
Jensen, Andrew M.,
851 Avant Ave., San Antonio.
Jensen, Martin H.,
115 N. Park Blvd., San Antonio.
Johns, Sylvia M.,
414 Navarro St., San Antonio.
Johnson, Charles W.,
2121 Fredericksburg Rd., San Antonio.
Johnson, Harry M., Jr.,
1620 Nix Prof. Bldg., San Antonio.
Johnson, Max E.,
1220 Med. Arts Bldg., San Antonio.
Johnson, Ted,
106 Produce Row, San Antonio.
Johnson, William J.,
7407 Broadway, San Antonio.
Jones, Dean B.,
730 Med. Arts Bldg., San Antonio.
Jones, George W.,
110 Rosemont Dr., San Antonio.
Jones, L. Bonham,
929 Manor Dr., San Antonio.
Kaliski, Sidney R.,
402 Fulton Ave., San Antonio.
Kass, Albert,
508 Med. Arts Bldg., San Antonio.
Keedy, David M.,
1216 S. Tex. Bldg., San Antonio.
Kennady, Donald S.,
906 Fredericksburg Rd., San Antonio.
Kenney, John W.,
So. Pacific Hosp., Houston.
Kenney, Nat M.,
222 E. Poplar St., San Antonio.
King, Thomas C.,
1104 S. Tex. Bldg., San Antonio.
King, W. A. (Hon.), Pandora.
Kitowski, Vincent J.,
P. O. Box 2545, Dhahran, Saudi Arabia.
Klecka, Theodore A.,
Med. Prof. Bldg., San Antonio.
Kline, Philip S.,
619 Med. Prof. Bldg., San Antonio.
Klinger, Paul E.,
517 Med. Prof. Bldg., San Antonio.
Koch, Alvis A.,
5148 Broadway, San Antonio.
Kohler, Colette M. (Int.),
328 Lamont Ave., San Antonio.
Koontz, Lee A.,
205 Camden St., San Antonio.
Kopecky, Joseph,
1414 Nix Bldg., San Antonio.
Kopecky, Joseph Willis,
1408 Nix Prof. Bldg., San Antonio.
Kopecky, Leon C.,
1414 Nix Bldg., San Antonio.
Kost, Louis B.,
521 Med. Prof. Bldg., San Antonio.
Kupper, Roland C.,
511 W. French Place, San Antonio.
Ladd, Graham B.,
424 Moore Bldg., San Antonio.
Lahourcade, Fred G.,
906 Fredericksburg Rd., San Antonio.
Lamb, Lawrence E.,
415 Timberlane Dr., San Antonio.
Lambrecht, Daniel E.,
303 Wyndale, San Antonio.
Lampe, Juliet H.,
545 New Moore Bldg., San Antonio.
Langlinais, Richard P., (Int.),
Santa Rosa Hosp., San Antonio.
Langner, C. Dwight,
440 Sheraton Dr., San Antonio.
Lawrence, Wilbert,
2315 Dragonwick, Houston.
Lea, Royal B., 1102 Lovera, San Antonio.
Lee, Jack B., 409 Camden St., San Antonio.
Lehmann, C. Ferd,
218 Med. Prof. Bldg., San Antonio.
Lemus, Leopoldo,
2302 S. Flores St., San Antonio.
Leopold, Henry N.,
602 W. French Pl., San Antonio.
LePere, Robert H.,
1424 Nix Bldg., San Antonio.
Letteer, C. Ralph, Jr.,
933 Nix Prof. Bldg., San Antonio.
Levine, Bernard R.,
1625 Nix Prof. Bldg., San Antonio.
Lewis, Wade H.,
2819 N. McCullough, San Antonio.
Livingston, Edward N.,
Box 1840, San Antonio.
Luedemann, Waldo S.,
820 Nix Prof. Bldg., San Antonio.
Lundgren, Rupert W.,
1609 Nix Prof. Bldg., San Antonio.
Magrish, Philip,
402 Fulton Ave., San Antonio.
Manhoff, Charles M.,
214 Med. Arts Bldg., San Antonio.
Manhoff, Louis J., (Hon.),
818 W. Woodlawn, San Antonio.
Manhoff, Louis J., Jr.,
303 Med. Arts Bldg., San Antonio.
Markette, Billy B.,
1400 N. McCullough, San Antonio.
Marshall, Joseph T.,
414 Robin Hood Pl., San Antonio.
Martin, Frank M.,
403 W. Summit, San Antonio.
Martinez, Joseph J.,
537 Moore Bldg., San Antonio.
Masters, Robert A.,
1723 Buena Vista, San Antonio.
Matthaei, Pearl V., Box 1840, San Antonio.
Matthews, John L.,
824 Nix Prof. Bldg., San Antonio.
Maurer, Robert T.,
1926 E. Lawndale Dr., San Antonio.
Maxwell, Ernest A.,
124 Dallas St., San Antonio.
Maxwell, W. Wortham,
626 Med. Arts Bldg., San Antonio.
May, Lester M.,
Med. Arts Bldg., San Antonio.
McCabe, Edward P., Jr.,
628 Med. Arts Bldg., San Antonio.
McComb, Asher R.,
1022 Nix Prof. Bldg., San Antonio.
McCorkle, Robert G., Jr.,
1503 Guadalupe St., Austin.
McCullough, David,
1214 Nix Prof. Bldg., San Antonio.
McCurdy, Marion W.,
1034 Nix Prof. Bldg., San Antonio.
McGehee, Charles L.,
605 Med. Arts Bldg., San Antonio.
McIntosh, John A., (Hon.),
208 W. Woodlawn Ave., San Antonio.
McKay, Patrick H.,
628 Med. Arts Bldg., San Antonio.
McKiski, Wendell E.,
720 Tuxedo, San Antonio.
McMahon, David T., Jr.,
901 Med. Arts Bldg., San Antonio.
McMillan, Orin P.,
South Texas Bldg., San Antonio.
Meadows, John C., Jr.,
502 Med. Prof. Bldg., San Antonio.
Melenyzer, Charles L.,
511 New Moore Bldg., San Antonio.
Mena, A. I., 103 Buena Vista, San Antonio.
Metzner, Wesley R. T.,
534 Dwight Ave., San Antonio.
Meyer, Gerhard A.,
1734 Nix Prof. Bldg., San Antonio.
Milburn, Graham B.,
1104 Nix Bldg., San Antonio.
Milburn, Kennedy A., (Dead).
Miller, John B., Jr.,
1704 E. Commerce St., San Antonio.
Miller, Ralph B.,
Box 8335 Laurel Ht., San Antonio.
Miller, Robert A.,
308 Park Hill Dr., San Antonio.
Mims, James L., Jr.,
211 Med. Arts Bldg., San Antonio.
Miniel, Pedro R.,
518 W. Houston, San Antonio.
Minter, Merton M.,
1734 Nix Prof. Bldg., San Antonio.
Mohle, Chester L.,
925 Contour Drive, San Antonio.
Monsalvo, Rudolph O.,
304 W. Houston St., San Antonio.
Montano, Ricardo G.,
603 W. Kings Hwy., San Antonio.
Montgomery, William D.,
511 W. French Pl., San Antonio.
Moore, George B., Jr.,
322 Med. Arts Bldg., San Antonio.
Moore, John M.,
818 Med. Arts Bldg., San Antonio.
Moore, Oliver S.,
107 N. Cibolo St., San Antonio.
Moore, S. Foster, Jr.,
401 W. Summit, San Antonio.
Morris, Marion H.,
804 Nix Prof. Bldg., San Antonio.
Morrison, James B.,
1734 Nix Bldg., San Antonio.
Moses, Louis E.,
414 Med. Prof. Bldg., San Antonio.
Mueller, Edwin L.,
1616 San Pedro, San Antonio.

Mueller, Edwin L., Jr.,
1616 San Pedro, San Antonio.
Mullen, Brooks W.,
1215 S. Texas Bldg., San Antonio.
Munslow, Ralph A.,
1233 Nix Prof. Bldg., San Antonio.
Murray, Neville,
827 Nix Prof. Bldg., San Antonio.
Nau, Cornelius H.,
351 E. Hildebrand, San Antonio.
Newby, Hi E., (Int.),
253 W. Strickland, Del Rio.
Newton, Jerry, 302 Croyden, San Antonio.
Nicholson, John R.,
508 Med. Arts Bldg., San Antonio.
Nisbet, Alfred A.,
700 S. McCullough, San Antonio.
Nitschke, Richard E.,
5307 Broadway, San Antonio.
Nixon, James W.,
1121 Nix Prof. Bldg., San Antonio.
Nixon, James W., Jr.,
1121 Nix Prof. Bldg., San Antonio.
Nixon, Pat I.,
1022 Med. Arts Bldg., San Antonio.
Nixon, Pat I., Jr.,
1022 Med. Arts Bldg., San Antonio.
Nixon, Robert R.,
401 Med. Prof. Bldg., San Antonio.
Norman, Ruskin C.,
1502 Nix Prof. Bldg., San Antonio.
Novak, Lumir F.,
St. Anthony Hotel, San Antonio.
Novoa, Enrique,
103½ Buena Vista, San Antonio.
O'Brien, Minnie C.,
1421 Nix Prof. Bldg., San Antonio.
Oglesby, Paul C.,
711 Kirk Place, San Antonio.
Oliver, David R.,
1605 Nix Prof. Bldg., San Antonio.
O'Neill, Francis E.,
1128 Nix Prof. Bldg., San Antonio.
O'Neill, James R.,
602 W. French Pl., San Antonio.
Orlando, Anthony M.,
1723 Buena Vista, San Antonio.
Orr, Wm. Robert,
810 Med. Arts Bldg., San Antonio.
Owens, Ross, 807 Gibbs Bldg., San Antonio.
Oxford, M. Bradfield,
1602 Nix Bldg., San Antonio.
Painter, T. S., Jr.,
VA Hospital, Ann Arbor, Mich.
Palmer, Joseph W.,
1120 S. Texas Bldg., San Antonio.
Park, J. Walter, III,
Nix Prof. Bldg., San Antonio.
Parrish, Robert E.,
527 Med. Arts Bldg., San Antonio.
Parsons, John C.,
1125 Nix Prof. Bldg., San Antonio.
Partain, Jack M.,
205 Camden St., San Antonio.
Paschal, Frank L.,
1222 Nix Prof. Bldg., San Antonio.
Passmore, Ben H.,
1732 Nix Prof. Bldg., San Antonio.
Passmore, Glenn G.,
1529 Nix Prof. Bldg., San Antonio.
Peterson, Robert C.,
510 Harrison Ave., San Antonio.
Peterson, Walter L.,
Box 7206, Hackberry Sta., San Antonio.
Pfeiffer, John P., Jr., (Int.),
1306 Oblate Dr., San Antonio.
Phillips, Claude M.,
444 Hammond Ave., San Antonio.
Phillips, Warren M.,
152 New Laredo Hwy., San Antonio.
Pinson, Charles C.,
923 Med. Arts Bldg., San Antonio.
Pipkin, J. Lewis,
714 Med. Arts Bldg., San Antonio.
Polka, James B.,
312 Med. Prof. Bldg., San Antonio.
Pomerantz, R. Bernard,
6936 San Pedro, San Antonio.
Posey, Frank M., Jr.,
101 McCullough Ave., San Antonio.
Post, S. Perry,
929 Manor Drive, San Antonio.
Poth, Duncan O.,
1230 Nix Prof. Bldg., San Antonio.
Potthast, Otto J.,
501 Gibbs Bldg., San Antonio.
Preacher, Madison L.,
916 E. Commerce, San Antonio.
Pressly, Thomas A.,
205 Camden St., San Antonio.
Price, Richard D.,
1233 Nix Bldg., San Antonio.
Pridgen, James E.,
1134 Nix Prof. Bldg., San Antonio.
Pridgen, John L.,
908 Med. Arts Bldg., San Antonio.
Pritchett, A. Belvin,
1017 Nix Prof. Bldg., San Antonio.
Pryor, Jessie W.,
Our Lady of Lake College, San Antonio.
Pyterek, Arthur B.,
723 Med. Arts Bldg., San Antonio.
Rabel, John E.,
902 Nix Prof. Bldg., San Antonio.
Rath, Albert E.,
1651 W. Mulberry, San Antonio.
Reeves, George D.,
202 Medford Dr., San Antonio.
Reily, William A.,
407 Med. Arts Bldg., San Antonio.
Reiter, Charles, Jr.,
1617 Nix Prof. Bldg., San Antonio.
Reppert, Lawrence B.,
Nix Prof. Bldg., San Antonio.
Ressmann, Arthur C.,
714 Med. Arts Bldg., San Antonio.
Reuter, Ernest G.,
611 Med. Arts Bldg., San Antonio.
Reveley, Hugh P.,
523 Med. Prof. Bldg., San Antonio.
Reveley, James E. L.,
2915 S. Presa St., San Antonio.
Rice, George W., (Inac.),
126 Medford Dr. S.E., San Antonio.
Richmond, Albert M.,
Nix Prof. Bldg., San Antonio.
Richmond, Harry A., Jr.,
608 Med. Prof. Bldg., San Antonio.
Richmond, James T.,
407 Bexar Dr., San Antonio.
Richter, James K.,
3721 S. Presa, San Antonio.
Ritch, Allen T.,
1717 Nix Prof. Bldg., San Antonio.
Roan, Omer,
1222 Nix Prof. Bldg., San Antonio.
Roberts, Edwin H.,
Box 7206, Hackberry Sta., San Antonio.
Robertson, Wilbur F.,
1426 Nix Prof. Bldg., San Antonio.
Rogers, Albert M.,
313 Med. Prof. Bldg., San Antonio.
Rosenzweig, Milton M.,
833 Med. Arts Bldg., San Antonio.
Ross, Rex R.,
1021 Nix Prof. Bldg., San Antonio.
Rouse, J. W. H.,
2621 N. Main Ave., San Antonio.
Russ, Witten B., (Emer.),
205 Camden St., San Antonio.
Russell, Dan A., Jr.,
429 Med. Arts Bldg., San Antonio.
Sacks, David R.,
206 Med. Prof. Bldg., San Antonio.
Saegert, August H.,
Med. Arts Bldg., San Antonio.
Saenz, Daniel,
1723 Buena Vista St., San Antonio.
Sammis, William L.,
325 Tuttle Road, San Antonio.
Sandler, Arthur S.,
141 Windsor Drive, San Antonio.
Santa Cruz, Edgar W.,
401 W. Summit, San Antonio.
Sawtelle, William W.,
636 New Moore Bldg., San Antonio.
Schattenberg, Herbert J.,
222 Med. Arts Bldg., San Antonio.
Schauer, Charles W.,
810 Med. Arts Bldg., San Antonio.
Schiffer, Sydney,
617 Med. Prof. Bldg., San Antonio.
Schwarting, Bland H.,
700 S. McCullough, San Antonio.
Schwartzberg, Sam,
South Texas Bldg., San Antonio.
Scull, T. Jackson,
1005 Nix Bldg., San Antonio.
Severance, Alvin O.,
205 Camden St., San Antonio.
Sharp, Thomas H.,
1634 Nix Prof. Bldg., San Antonio.
Shaver, Benjamin B.,
211 Med. Prof. Bldg., San Antonio.
Shaw, Thad (Inac.),
Gunter Hotel, San Antonio.
Shefts, Lawrence M.,
209 Paseo Encinal, San Antonio.
Shepherd, Walter F.,
1401 Highland, San Antonio.
Shingle, Robert Charles,
3656 Culebra Rd., San Antonio.
Shipman, E. D., (Inac.),
551 Cincinnati, San Antonio.
Shotts, Chester C.,
915 Med. Arts Bldg., San Antonio.
Sichi, William T.,
420 Med. Prof. Bldg., San Antonio.
Siever, James M.,
318 Med. Prof. Bldg., San Antonio.
Simpson, John W.,
Robt. B. Green Hosp., San Antonio.
Skinner, Ira C., 124 Dallas St., San Antonio.
Skripka, Charles F.,
3721 S. Presa St., San Antonio.
Slayter, James E.,
126 E. Woodlawn, San Antonio.
Smith, Forrest M., Jr.,
227 E. Hildebrand, San Antonio.
Smith, John M., Jr.,
205 Camden St., San Antonio.
Smith, Thomas B.,
118 Frances Jean Dr., San Antonio.
Smyth, Rodger,
San Antonio State T.B. Hosp., San Antonio
Snip, Russell T., 505 Howard, San Antonio.
Soma, Yone, 102 S. Rosillo, San Antonio.
Sotoodeh, Bagher,
1717 Nix Prof. Bldg., San Antonio.
Sparks, John E., (Inac.),
423 Hot Wells Blvd., San Antonio.
Spector, Morris, (Int.),
1627 W. Mulberry, San Antonio.
Stain, Stanley,
704 N. New Braunfels, San Antonio.
Stansell, Paul Q.,
2446 W. Summit, San Antonio.
Stanton, William P.,
815 S. Texas Bldg., San Antonio.
Steed, P. Franklin,
1525 Nix Prof. Bldg., San Antonio.
Steinberg, Fred W.,
1525 Nix Prof. Bldg., San Antonio.
Stewart, C. Scott,
123 Ogden Lane, San Antonio.
Stieler, Albert,
1006 Med. Arts Bldg., San Antonio.
Stovall, Virginia S.,
1116 S. Texas Bldg., San Antonio.
Strauch, James H.,
610 Med. Prof. Bldg., San Antonio.
Strozier, William E.,
917 Nix Prof. Bldg., San Antonio.
Sullivan, Thomas P.,
616 Moore Bldg., San Antonio.
Surber, Maxine J.,
114 General Krueger, San Antonio.
Sutton, Robert S., Jr.,
711 W. Kirk, San Antonio.
Sutton, Robert S., Sr., (Inac.),
711 W. Kirk, San Antonio.
Sweet, Horace C.,
205 Camden St., San Antonio.
Swinny, Boen,
314 Med. Arts Bldg., San Antonio.
Sykes, E. Meredith,
925 Nix Prof. Bldg., San Antonio.
Sykes, Edwin M., Jr.,
927 Nix Prof. Bldg., San Antonio.
Taylor, Charles W., (Hon.),
276 W. Mandalay Dr., San Antonio.
Taylor, Thomas S.,
916 Nix Prof. Bldg., San Antonio.
Templeton, R. D., 133 Handley, San Antonio.
Tennison, Charles W., (Pres.),
511 Med. Prof. Bldg., San Antonio.
Terrell, Robert W. B.,
1634 Nix Prof. Bldg., San Antonio.
Thaddeus, Aloysius P.,
502 Med. Prof. Bldg., San Antonio.
Thaggard, Alvin, Jr.,
1129 Nix Bldg., San Antonio.
Thomas, Robert P., Jr.,
1002 Nix Prof. Bldg., San Antonio.
Thornton, Melvin L.,
351 E. Hildebrand, San Antonio.
Timmins, Oliver H., (Hon.),
1211 Med. Arts Bldg., San Antonio.
Timmins, Oliver H., Jr.,
1211 Med. Arts Bldg., San Antonio.
Tippit, Nathaniel G.,
Mayo Foundation, Rochester, Minn.
Todd, David A.,
1502 Nix Prof. Bldg., San Antonio.
Trevino, Saul S.,
318 N. Santa Rosa, San Antonio.
Trimmer, Kenneth E.,
645 Garrity Road, San Antonio.
Tritt, Earl F.,
1201 W. Woodlawn, San Antonio.
Tucker, Lewis E.,
1402 Nix Bldg., San Antonio.
Tucker, Victor C.,
1402 Nix Prof. Bldg., San Antonio.

Ullrich, Fredric W.,
1239 Basse Rd., San Antonio.
Urrutia, Adolfo,
210 N. Santa Rosa, San Antonio.
Urrutia, Carlos,
212 N. Santa Rosa, San Antonio.
Veit, John P., (Mil.),
3810th USAF Hosp., Maxwell AFB, Ala.
Venable, Charles S., (Emer.),
154 Park Hill Dr., San Antonio.
Von Bose, Edda,
914 Kayton Ave., San Antonio.
Wait, Raymond B.,
929 Manor Dr., San Antonio.
Walker, Carl J.,
719 E. Houston, San Antonio.
Walker, Dorothy J. B.,
97th Gen. Hosp., New York, N. Y.
Walker, H. Vincent,
Nix Prof. Bldg., San Antonio.
Waller, Edward P.,
205 Camden St., San Antonio.
Walling, Russell G.,
211 Richmond Ave., San Antonio.
Walsh, John N.,
508 Med. Prof. Bldg., San Antonio.
Walthall, Walter,
1114 S. Texas Bldg., San Antonio.
Ward, Mildred E.,
104 Babcock Rd., San Antonio.
Watson, I. Newton,
906 Fredericksburg Rd., San Antonio.
Watts, John A., (Hon.),
805 Med. Arts Bldg., San Antonio.
Weatherford, Eddie W.,
205 Camden St., San Antonio.
Weatherford, Jack M.,
205 Camden St., San Antonio.
Webb, John B., Jr.,
205 Camden, San Antonio.
Weiner, Bernard K.,
929 Manor Dr., San Antonio.
Weiss, Victor J.,
509 Med. Arts Bldg., San Antonio.
Weixel, Francis X.,
824 Nix Prof. Bldg., San Antonio.
Welch, Eldred E., Moore Bldg., San Antonio.
Wells, Arthur M., Jr.,
1706 E. Commerce, San Antonio.
Wells, Dolph T.,
3506 S. New Braunfels, San Antonio.
Welsh, Virginia, C.,
145 Parland, San Antonio.
Whittier, Charles A.,
928 E. Crockett, San Antonio.
Wier, Vernon S., 107 Eads Av., San Antonio.
Wiesner, Jerome J.,
1128 Nix Prof. Bldg., San Antonio.
Wigodsky, Herman S.,
420 E. Houston, San Antonio.
Wilkinson, John M.,
307 Med. Arts Bldg., San Antonio.
Willerson, Eleanor T.,
108 Sheraton, San Antonio.
Willerson, J. E., (Hon.),
144 Barilla, San Antonio.
Willerson, Wm. D.,
1028 Nix Prof. Bldg., San Antonio.
Williams, Philip T., Jr.,
929 Manor Dr., San Antonio.
Wilson, Harry G.,
6612 S. Flores, San Antonio.
Winter, John W.,
350 Terrell Rd., San Antonio.
Woldman, Alvin L.,
929 Manor Dr., San Antonio.
Wolf, William M.,
1717 Nix Prof. Bldg., San Antonio.
Wong, Peter Y.,
Nix Prof. Bldg., San Antonio.
Worsham, John W.,
1400 McCullough, San Antonio.
Wright, Jack M.,
403 W. Summit, San Antonio.
Wyatt, Byron W.,
603 Navarro St., San Antonio.
Ximenes, E. T.,
318 N. Santa Rosa, San Antonio.
Ydens, Jan W.,
Box 7206, Hackberry Sta., San Antonio.
Zeitlin, S. P., Box 6115, San Antonio.
Zier, James R.,
2126 W. Wiedwood, San Antonio.
Zink, Pearl L.,
615 Med. Arts Bldg., San Antonio.
Zuschlag, Ella,
611 Med. Prof. Bldg., San Antonio.

COMAL

Bergfeld, Arthur W. C.,
Box 49, New Braunfels.
Bergfeld, Jack A.,
173 S. Gilbert, New Braunfels.
Eiband, John M., (Mil.),
P. O. Box 31, New Braunfels.
Frueholz, Bertha, Box 230, New Braunfels.
Frueholz, Fred, Box 230, New Braunfels.
Frueholz, Frederick, Jr.,
305 S. Seguin Ave., New Braunfels.
Hinman, Alexander J.,
Box 79, New Braunfels.
Karbach, Hylmar E.,
Box 700, New Braunfels.
Karbach, Hylmar E., Jr., (Mil.),
New Braunfels.
Langston, John H., Jr.,
921 Booneville, New Braunfels.
Nations, Frankie Nell,
227 Clemens, New Braunfels.
Schaefer, John K., (Pres.),
P. O. Box 487, New Braunfels.
Schleicher, Leroy C.,
770 Roosevelt, New Braunfels.
Sullivan, William W.,
532 N. Union, New Braunfels.
Woodward, Stanley M., (Sec'y.),
535 S. Seguin, New Braunfels.
Zipp, Raymond D.,
P. O. Box 632, New Braunfels.

GONZALES

Elder, Nathan A., (Pres.), Nixon.
Kirkpatrick, Marjorie,
Warm Springs Foun., Gonzales.
Nixon, Sam A., Jr., Box 548, Nixon.
Ponder, Stewart M., Waelder.
Price, James C., (Sec'y.),
521½ St. Joseph, Gonzales.
Shelby, David M., Gonzales.
Sievers, Walter A., Gonzales.
Stahl, Louis J., Box 184, Gonzales.
Von Werssowetz, Odon F.,
Warm Springs Found., Gonzales.

GUADALUPE

Bachman, George P., (Pres.),
110 W. Mountain, Seguin.
Douthett, J. C. B., 110-A N. Austin, Seguin.
Friday, Clarence B., (Inac.),
104 N. Crockett, Seguin.
Goetz, Joseph T., 109 W. Gonzales, Seguin.
Heinen, Allen I., 1025 N. Austin, Seguin.
Knolle, Robt. L., Jr.,
110 W. Mountain, Seguin.
Moore, Melba M.,
1025 N. Austin St., Seguin.
Moore, Raymond T.,
1025 N. Austin St., Seguin.
Mueller, John A., 1025 N. Austin. Seguin.
Raetzsch, Andrew, 109 W. Gonzales, Seguin.
Randolph, Vivien P., Schertz.
Ray, Robert S., (Sec'y).,
105 N. River St., Seguin.
Weiss, Leroy E., 1025 N. Austin St., Seguin.
Williams, Jesse B., 110 W. Mountain, Seguin.

KARNES-WILSON

Blake, John V., Jr., Floresville.
Bonnstetter, Harold J., Box 638, Kenedy.
Boykin, Solomon R., Floresville.
Day, Ancie Fred, Jr., P. O. Box 357, Runge.
Edwards, Thomas P., (Sec'y.), Karnes City.
Mills, William C., Jr., Kenedy.
Oxford, Jerry W., (Hon.), Floresville.
Quillian, Causey C.,
330 W. Live Oak, Kenedy.
Shannon, Shelby E., (Pres.),
P. O. Box 1098, Karnes City.
Ware, Ella (Hon.), Stockdale.

KERR-KENDALL-GILLESPIE-BANDERA

Bell, William E., Kerrville.
Birt, John B., Harper.
Brandenstein, Luise C., Kerrville.
Brown, Dor W., Jr.,
109 S. Adams, Fredericksburg.
Byrd, William C., Jr.,
325 Peterson Hosp., Kerrville.
Day, Harold C., 31 Main St., Boerne.
Drane, Hugh A., Jr., Kerrville.
Dyer, Edward L., Kerrville.
Eley, Julia S., (Sec'y.), Kerrville.
Feller, Lorence W., Fredericksburg.
Gallatin, Herbert H., (Hon.), Kerrville.
Gregg, William E., Kerrville.
Gremmel, Gilbert C., P. O. Box 428, Boerne.
Guill, Russell E.,
Sid Peterson Hosp., Kerrville.
Haffner, Vorha M. B., Box 163, Kerrville.
Harzke, Otto F., Comfort.
Hill, W. Herbert, Fredericksburg.
Jackson, J. Warren, VA Hospital, Kerrville.
Jones, Chas. C., Jr., Kerrville.
Jones, Charles C., Sr., (Hon.), Comfort.
Keyser, Lester L.,
115 S. Adams, Fredricksburg.
Knapp, Dwight R.,
317 Peterson Hosp., Kerrville.
Matthews, Choice B.,
305 Peterson Hosp., Kerrville.
Meador, George D.,
Bandera Hosp. Bldg., Bandera.
Monroe, Myrick L., Box 375, Kerrville.
Packard, Duan E., Kerrville.
Perry, J. Hardin, Fredericksburg.
Rague, Edmund F., 125 Loop 13, Kerrville.
Ross, Luther W., P. O. Box 711, Kerrville.
Seidel, Joshua, (Pres.),
1104 W. Main, Kerrville.
Simpson, Robt. Keith, (Hon.), Kerrville.
Springall, Walton H., Fredericksburg.
Stein, Edward F., Jr.,
258 E. Main St., Fredericksburg.
Thorne, Frederic H., (Hon.),
1623 E. Pyron Rd., San Antonio.
Wiedeman, John E., Junction.

LaSALLE-FRIO-DIMMIT

Barnard, W. L., (Hon.), Carrizo Springs.
Brown, Dorothy V. M., Box 53, Catarina.
Crawford, John M., Carrizo Springs.
Lindley, Calvin D., (Hon.), Carrizo Springs.
McKinley, Robert L., (Mil.), Pearsall.
Myers, Clyde P., Cotulla.
O'Connor, Timothy D., (Pres.), Pearsall.
Pickett, B. E., Sr., Carrizo Springs.
Pickett, Jack B. E., Jr.,
Box 398, Carrizo Springs.
Primomo, John S., Dilley.
Primomo, Marion P., (Sec'y.), Dilley.
Wilson, Donald K., Box 55, Carrizo Springs.
Wilson, Emmett N., Jr., Box 696, Pearsall.
Wilson, Wm. S., Jr.,
498 Clark St., Carrizo Springs.

MEDINA-UVALDE-MAVERICK-
VAL VERDE-EDWARDS-REAL-KINNEY-
TERRELL-ZAVALA

Allison, George M., (Pres.),
126 W. Nopal St., Uvalde.
Brittain, Mary Ruth,
204 E. Zavala, Crystal City.
Burditt, Bucky L., 901 Griner, Del Rio.
Calderon, Fermin, 838 S. Main St., Del Rio.
Cartall, Louis M.,
300 Dignowity St., Del Rio.
Cox, George W., (Hon.),
8829 Croes Dr., Houston.
Cunningham, George B., Uvalde.
Dimmitt, Dean P., Uvalde.
Donaldson, Elizabeth, Ross Bldg., Del Rio.
Eads, Ray A., Uvalde.
Eckert, Robert R.,
Castroville Hosp. and Clinic, Castroville.
Fly, Sterling H., Jr.,
105 N. Piper Lane, Uvalde.
Folsom, Charles W.,
1716 University Ave., Berkeley, Calif.
Gates, Ellis F., 577 Ceylon, Eagle Pass.
Graham, Robert N., Del Rio.
Herrmann, George H., (Sec'y.),
301 Del Rio Bk. Bldg., Del Rio.
Hyslop, James R., Ross Drug Co., Del Rio.
Johnson, Thomas M.,
300 Dignowity St., Del Rio.
Kaback, Harry,
421 Washington St., Eagle Pass.
LaForge, Hershall, Uvalde.
Lewis, B. Oliver, P. O. Box K, Eagle Pass.
McWilliams, William R., Del Rio.
Meredith, William P., Del Rio.
Merritt, George H., (Hon.),
Rocksprings Road, Uvalde.
Meyer, Walter B., Hondo.
Mims, Joe M., 1115 17th St., Hondo.
Montemayor, Raul M.,
333 Ceylon St., Eagle Pass.
Peters, Leo E., Devine.
Poindexter, Cary A., Crystal City.
Pratt, Frank H., Rocksprings.
Rankin, Richard C., Jr.,
121 W. South St., Uvalde.
Rodriguez, Simon, Del Rio.
Samsel, Theodore B., Jr.,
217 N. 1st Ave., Crystal City.
Spencer, John C., 212 Maverick, Crystal City.
Sutton, Claud R., Jr., 126 W. Oak, Uvalde.
Wurzbach, Fay, Castroville.

SIXTH DISTRICT

Dr. S. W. Bohmfalk, Weslaco, Councilor

BEE-LIVE OAK-McMULLEN

Edmondson, John W.,
908 N. St. Marys, Beeville.
Kirkland, Luman W.,
310 N. St. Marys, Beeville.
Lancaster, Howard E., Box 559, Beeville.
McNeill, Scott E., Beeville.
Miller, Ernest E., Beeville.
Morron, Clyde R., George West.
Muecke, Elmo W., (Pres.), Three Rivers.
Reagan, James L.,
310 N. Washington, Beeville.
Reagan, John W., 908 N. St. Marys, Beeville.
Reagan, Tom B., Beeville.
Sansom, George W. (Sec'y.), George West.

BROOKS-DUVAL-JIM WELLS

Albert, Richard O., (Sec'y.),
64 N. Wright St., Alice.
Allison, Albert M., 1031 E. Main St., Alice.
Buck, Haldor R., Premont.
Crisp, Euell W., Jr.,
501 N. Reynolds St., Alice.
Davis, Glenn B., Box 576, Falfurrias.
Glendenning, F. C., Hebbronville.
Gonzalez, Juan C., Benavides.
Haag, Edmund L., Jr., Freer.
Hocott, Joseph F., Freer.
Howard, Glenn T., Box 1277, Alice.
Joseph, Philip S., Alice.
Moet, John Allen, Orange Grove.
Moore, Victor, Premont.
Newkirk, William H., (Pres.),
1031 E. Main St., Alice.
O'Neil, Andrew W., Falfurrias.
Penly, Richard S., Falfurrias.
Riddle, Riley N., 70 N. Wright St., Alice.
Turnham, John C., Jr.,
68 N. Wright St., Alice.
Virgin, Edwin P.,
501 N. Reynolds, Alice.
Wilder, Lowell E., Falfurrias.
Williams, J. Harold, Alice.
Wyche, Geo. G., Jr.,
310 N. Wright St., Alice.
Wyche, Geo. G., Sr.,
310 N. Wright St., Alice.

CAMERON-WILLACY

Allen, George Earl (Mil.), Harlingen.
Amidon, Vivien M.,
McKelvey Bldg., Harlingen.
Ashcraft, E. Jeff, Jr.,
613 W. Filmore, Harlingen.
Atchison, Martin V.,
1622 Ed Carey Dr., Harlingen.
Baden, Ervin E.,
152 S. 6th St., Raymondville.
Baden, Wayne F.,
Medical Arts Bldg., Raymondville.
Beazley, H. Liston,
1716 Ed Carey Dr., Harlingen.
Bedri, Marcel R.,
501 McKelvey Bldg., Harlingen.
Benavides, Simon I., Jr.,
335 East Kimball, Raymondville.
Bennack, Gene E., Box 778, Raymondville.
Bennack, George E.,
152 S. 6th St., Raymondville.
Berrey, Bedford H., (Mil.),
108 Lyman Drive, San Antonio.
Binney, Charles, II,
1720 Ed Carey Dr., Harlingen.
Bleakney, Phil A.,
214 E. Harrison, Harlingen.
Bowyer, Charles H.,
P. O. Box 535, Los Fresnos.
Breeden, Roy F.,
105 W. Elizabeth, Brownsville.
Breyer, Amy, 105 W. Elizabeth, Brownsville.
Brown, John F., Jr.,
315 N. Sam Houston, San Benito.
Caldeira, Frederick D.,
113 W. Van Buren, Harlingen.
Calderoni, Francisco F.,
57 W. Elizabeth, Brownsville.
Cannon, George M.,
48 W. Levee St., Brownsville.
Carranza, Enrique M., Brownsville.
Casey, James D.,
400 W. Highway 77, San Benito.
Cash, Clarence M., (Hon.),
1040 N. Bowie, San Benito.
Chase, Ned B., Jr., (Mil.), San Benito.
Childress, James L.,
1710 Ed Carey Dr., Harlingen.
Clarke, James Y.,
212 E. Harrison, Harlingen.
Cope, Solomon F., 1120 Garcia, Port Isabel.
Cowgill, David M.,
1135 N. Sam Houston, San Benito.
Davis, Lum M., Embee Bldg., Harlingen.
De La Garza, Enrique, Box 2042, Brownsville.
Destefano, Frederick W.,
55 W. Elizabeth, Brownsville.
Dieck, John A., 211 E. Harrison, Harlingen.
Duncan, George W.,
1710 Ed Carey Dr., Harlingen.
Dyo, Kaoru, 324 E. Harrison St., Harlingen.
Eckley, Robert, 33 E. Elizabeth, Brownsville.
Englerth, Fred L., 306 S. 3rd St., Harlingen.
Flory, David W., P. O. Box 271, Harlingen.
Freeman, George A.,
1155 Parkwood Pl., Brownsville.
Gallaher, George L.,
McKelvey Bldg., Harlingen.
George, James C., II,
705 W. Jefferson, Brownsville.
Goerger, Verne F.,
665 W. Riggs, Raymondville.
Guerrero, Emilio,
1049 E. Washington, Brownsville.
Haas, Nelson W.,
380 N. Sam Houston, San Benito.
Hamilton, Oscar A.,
310 S. 3rd St., Harlingen.
Harren, Henry F., Jr., (Mil.),
800 Tennessee, Weslaco.
Harrop, L. Louis,
322 E. Monroe Ave., Harlingen.
Hartman, John T.,
1616 Ed Carey Dr., Harlingen.
Hawkins, Beatrice W.,
P. O. Box 1747, Brownsville.
Hawkins, W. W.,
105 W. Elizabeth St., Brownsville.
Hecht, Rudolph C., P. O. Box 686, La Feria.
Heins, Donald E.,
336 S. Eighth St., Raymondville.
Heins, Otto H., Raymondville.
Higgs, Paul C.,
212 Clarke & Courts Bldg., Harlingen.
Hockaday, James A., Port Isabel.
Hume, Evan B.,
105 W. Elizabeth, Brownsville.
Jackson, Robert C., 1421 Bowie, Harlingen.
Jaros, Stanislaus H.,
308 S. 3rd St., Harlingen.
Jondahl, Willis H.,
P. O. Box 1727, Harlingen.
Jones, Lee Dale,
525 Villa Maria Blvd., Brownsville.
Keeble, Leon, Jr.,
525 Villa Maria Blvd., Brownsville.
Kinder, Thurman A., Jr.,
248 E. Levee St., Brownsville.
Krishna, Ikbal,
47 W. Elizabeth St., Brownsville.
Kruisheer, H. E. J.,
817 E. Harrison, Harlingen.
Kuppinger, John C.,
613 W. Filmore, Harlingen.
Lamm, Annie T.,
1025 S. 16th St., Harlingen.
Lamm, Heinrich,
1025 S. 16th St., Harlingen.
LaMotte, Thomas J.,
613 W. Filmore, Harlingen.
Lancaster, David D.,
501 W. McKinley St., Harlingen.
Lawrence, Oscar V., Box 228, Brownsville.
Longoria, Vidal, 800 E. Adams, Brownsville.
Loyd, Edward M., Box 2061, Harlingen.
Lyle, Charles F., Box 996, San Benito.
McLean, Edwin P.,
24 S. E. St. Charles, Brownsville.
Merrill, Samuel J.,
105 W. Elizabeth, Brownsville.
Miller, Harry Allen, Jr.,
301 E. Washington, Brownsville.
Miller, John B.,
301 E. Washington, Brownsville.
Moet, Joe Louis, La Feria.
Nickell, David F.,
322 E. Harrison, Harlingen.
Noell, L. Pope, Jr.,
1202 S. 15th St., Harlingen.
Olcott, Cornelius, Jr.,
218 E. Harrison, Harlingen.
Packard, John P.,
214 E. Harrison, Harlingen.
Palmer, Mahlon P.,
1314 E. Hwy 77, Harlingen.
Para, Andrew W.,
210 1st Natl. Bk., Brownsville.
Parker, S. Mitchell,
480 N. Sam Houston, San Benito.
Pearson, Bernard S.,
P. O. Box 390, Harlingen.
Petta, George H., P. O. Box 1727, Harlingen.
Poole, Pierre P., (Pres.),
44 East Levee, Brownsville.
Quintanilla, Carlos J., Box 592, Harlingen.
Reeder, John W., Jr.,
216 E. Harrison, Harlingen.
Rentfro, James B.,
2109 Mt. Royal Terrace, Fort Worth.
Rodriguez, Hesiquio,
P. O. Box 1148, Harlingen.
Ross, William F.,
315 N. Sam Houston, San Benito.
Roth, Karl A., 105 W. Elizabeth, Brownsville.
Salinger, Leland M., (Sec'y.),
105 W. Elizabeth, Brownsville.
Scales, Hunter L., Jr.,
375 N. Sam Houston, San Benito.
Scanlan, Nestor,
450 W. Jefferson, Brownsville.
Shafer, Troy A., 561 Lake Drive, Harlingen.
Sherman, K. C., 300 S. 4th St., Harlingen.
Shultz, Norma P.,
1314 E. Hwy. 77, Harlingen.
Smith, Dudley W.,
1614 Ed Carey Dr., Harlingen.
Smith, Robert N., Jr.,
1616 Ed Carey Dr., Harlingen.
Spence, Charles H., Jr., Raymondville.
Stephens, John M.,
P. O. Box 1733, Brownsville.
Tewell, Howard E., Jr.,
1716 Ed Carey Dr., Harlingen.
Thurman, George E.,
222 E. Harrison Ave., Harlingen.
Walsworth, Frank D.,
112½ S. First, Harlingen.
Watkins, John C., (Hon.),
Box 866, Harlingen.
Welty, John Allen,
1720 Ed Carey Dr., Harlingen.
Willeford, George,
1720 Ed Carey Dr., Harlingen.
Wise, Samuel P., III,
400 W. Hiway 77, San Benito.
Withers, John C.,
1154 E. Elizabeth, Brownsville.
Works, Bynum M.,
105 W. Elizabeth, Brownsville.
Works, Lee, 105 W. Elizabeth, Brownsville.
Youngberg, Stephen A., Box 404, Port Isabel.

HIDALGO-STARR

Allen, Francis A., 112 E. 11th, Mission.
Bazan, Carlos, Jr., (Int.),
1024 Church, Galveston.
Bennett, Frank W., (Hon.), (Dead).
Blocker, William P., P. O. Box 887, Donna.
Bohannon, Richard F., 225 West Park, Pharr.
Bohmfalk, Stanley W.,
587 Kansas Ave., Weslaco.
Brandes, Gerald E.,
500 South Main, McAllen.
Burnett, Thomas R., (Hon.), Mission.
Caldwell, James W.,
606 S. Broadway, McAllen.
Cantu, Carlos L., 520 Third St., Mercedes.
Casso, Ramiro R., 620 S. Main St., McAllen.
Caton, McKee, 1607 N. 8th St., McAllen.
Clark, Richard G, 308 S. Main, McAllen.
Cuellar, Armando,
101-A S. Kansas Ave., Weslaco.
DeWitt, Joseph L., 201 N. Broadway, Elsa.
Douglass, Daniel D.,
416 S. Broadway, McAllen.
Duncan, Wallace H.,
1411 Beaumont, McAllen.
Edwards, Thomas G., 301 Texas, Mercedes.
Ellis, Jack R., McCalip-Ivy Hosp., Weslaco.
Evans, Sheridan S.,
619 S. Broadway, McAllen.
Fitch, James F., 817 Quince, McAllen.
Forcher, Henry, 521 S. 12th St., Edinburg.
Frink, Berton F.,
M. & J. Nelson Bldg., McAllen.
Garcia, Octavio, 720 S. Main, McAllen.
Garcia, Raul, 620 S. Broadway, McAllen.
Garcia-Esteves, Juan, 820 Pecan, McAllen.
Garza, Rafael, 718 S. Main, McAllen.
Gilliam Hilburn D., (Pres.),
416 S. Broadway, McAllen.
Gordon, Clarence E.,
412 S. Main St., McAllen.
Graham, Ronald A., 710 S. Cage, Pharr.
Guerra, Gilbert A., 107 S. 13th St., Edinburg.
Guerra, Lauro G., 701 S. 16th St., McAllen.
Hamme, Ralph E., 505 S. Closner, Edinburg.
Hatfield, Walter H., 1205 Chicago, McAllen.

Heidrick, Daniel L.,
446 Texas Ave., Mercedes.
Hoffmaster, Vance D.,
521 S. Closner, Edinburg.
Hough, Travers E., Jr.,
509 S. Closner, Edinburg.
Ice, Noel V., 901 Quince Ave., McAllen.
Ivy, J. Bryan, 427 Kansas, Weslaco.
Johnston, Robert H., Mercedes.
Kellar, Robert J., 530 S. Texas, Weslaco.
Kuhl, Ivan W., 414½ S. Main, McAllen.
Lancaster, George M., Weslaco.
Lawler, Marion R., 418 S. Texas, Mercedes.
Livengood, Gerald S., (Sec'y.),
1122 Conway, Mission.
Long, William H., 129 E. Caffery, Pharr.
Lubben, John F., Jr.,
1414 Galveston, McAllen.
Marsh, Elinor E., 713 Vine, McAllen.
Martin, James C., Jr., 1122 Conway, Mission.
Matthews, John W.,
509 S. Closner, Edinburg.
Maxwell, Walter J., Jr.,
500 S. Main St., McAllen.
McCalip, Edwin L., (Hon.), Weslaco.
McKinsey, S. Joe, 802 South Main, McAllen.
Mims, Charles H., 1301 Conway, Mission.
Mock, Duane V., 109 E. 7th, San Juan.
Munal, H. Deane, Box 66, San Juan.
Narro, George, 817 Quince, McAllen.
Nordmeyer, Arthur F.,
105 W. 9th St., Mission.
North, Norman T., 1008 Doherty, Mission.
Osborn, Frank E., (Hon.),
P. O. Box 208, McAllen.
Osborn, Robert W., Box 329, McAllen.
Panzer, Ralph P., 212 E. 5th St., Weslaco.
Queen, Charles R., 305 Ebony Ln., Edinburg.
Rabinowitz, George E.,
Prof. Arts Bldg., McAllen.
Rabinowitz, Haskell I., 817 Quince, McAllen.
Ramirez, Mario E., Roma.
Reed, Walter Earl, 107 East 7th, San Juan.
Rhea, Keith, Box 221 RFD 1, McAllen.
Riley, Pat, 213 E. 10th St., Mission.
Rodriguez, M. J.,
308 E. 4th St., Rio Grande City.
Sanchez, Santiago A.,
817 Quince Ave., McAllen.
Scott, Kincy J., 402 S. Cage, Pharr.
Shamburger, W. H., Jr.,
P. O. Box 308, San Juan.
Sherfy, Hilde V. W.,
312 S. 12th St., McAllen.
Smith, Edward G., (Hon.), Mercedes.
Smith, Lloyd, 708 South Main, McAllen.
Southwick, Lloyd M., Box 398, Edinburg.
Sybilrud, Hjalmer W.,
620 S. Brdwy., McAllen.
Terrell, Pruitt D.,
606 S. Brdwy., McAllen.
Trevino, Jorge H.,
718 S. Main St., McAllen.
Walker, Ottis, 209 East 12th, Mission.
Webb, John B., 104 N. Fourth St., Donna.
Westphal, Herbert M., 530 S. Texas, Weslaco.
Whigham, Herschel E.,
412 S. Main, McAllen.
Whigham, William E., (Hon.),
414 S. Broadway, McAllen
Wooldridge, Dean H., 817 Quince, McAllen.
Young, Ray L., Box 307, Mission.

KLEBERG-KENEDY

Barnett, Lawrence M., Box 608, Bishop.
Boyd, Newell D.,
227 W. Kleberg St., Kingsville.
Dunn, S. Chester,
831 Alexander St., Kingsville.
Ewert, William A.,
704 E. Ceasar St., Kingsville.
Gaston, Earl, 722 E. Ragland St., Kingsville.
Ginther, Clarke E., Box 308, Bishop.
Greif, Emmett W.,
613 E. Ragland St., Kingsville.
Higgins, Frank B.,
230 W. Yoakum St., Kingsville.
Jones, A. C., 730 W. Lee St., Kingsville.
Lambeth, Charles B.,
4317 S½ St., Galveston.
Peace, Dewey W., Box 608, Bishop.
Peace, Dewey W., Jr., (Mil.),
FPO 128 Navy, San Francisco, Cal.
Ramey, Lindell E. (Sec'y),
Box 431, Kingsville.
Scales, James R.,
227 W. Kleberg St., Kingsville.
Sublett, Collier M., 723 W. Lee St., Kingsville.
Walling, Bert H. Jr.,
227 W. Kleberg, Kingsville.
Wiles, William T. (Hon.), Riviera.

NUECES

Abbey, Joseph A.,
2451 Morgan, Corpus Christi.
Ahern, Gerald S.,
1017 Santa Fe, Corpus Christi.
Alsop, Joseph F.,
237 Med.-Dental Bldg., Corpus Christi.
Anderson, William E.,
1001 Louisiana, Corpus Christi.
Appel, Myron H.,
1200 Santa Fe, Corpus Christi.
Arnim, Landon C.,
2424 Morgan, Corpus Christi.
Arnold, Harrell R.,
1214 Santa Fe, Corpus Christi.
Ashmore, Alvin J.,
225 Med.-Dental Bldg., Corpus Christi.
Barber, Ivan J. Jr., (Int.),
4617 Christie, Corpus Christi.
Barnard, James L.,
1240 3rd St., Corpus Christi.
Barnard, Wm. C., 1240 3rd St., Corpus Christi.
Barnes, George B.,
2400 Morgan Ave., Corpus Christi.
Bernwanger, Damon C.,
2935 Norton, Corpus Christi.
Bickley, Estill T., 2524 Morgan, Corpus Christi.
Blaine, Alva L., 2466 Morgan, Corpus Christi.
Blaine, Mose H., Jr.,
2466 Morgan, Corpus Christi.
Blair, John V.,
308 Wilson Bldg., Corpus Christi.
Bounds, Lloyd D.,
15 Medical Center, Corpus Christi.
Brown, Walter C.,
2550 Morgan, Corpus Christi.
Bryson, J. Gordon Jr.
1209 Santa Fe, Corpus Christi.
Buchanan, A. C. (Mil.), Corpus Christi.
Burns, Herbert V.,
2430 Morgan, Corpus Christi.
Cameron, Ralph H. Jr.,
2433 Morgan, Corpus Christi.
Carlson, O. Sherman,
1755 Santa Fe, Corpus Christi.
Carr, Robert H., 916 Ayers St., Corpus Christi.
Casillas-Aguayo, Luis,
913 S. Port Ave., Corpus Christi.
Chriss, John W., 2436 Morgan, Corpus Christi.
Clark, Chas. S.,
233 Med.-Dental Bldg., Corpus Christi.
Clark, Dan H. (Sec'y),
1001 Louisiana, Corpus Christi.
Cline, William B., Jr.,
2471 Morgan, Corpus Christi.
Cluff, Frederick M., 401 Cole, Corpus Christi.
Coleman, Sherman T.,
1001 Louisiana, Corpus Christi.
Colyer, George E.,
1001 Louisiana, Corpus Christi.
Concklin, Charles L.,
P. O. Box 3475, Corpus Christi.
Conolly, Sidney M.,
1300 3rd St., Corpus Christi.
Crain, Carroll F.,
1214 Santa Fe, Corpus Christi.
Cullen, Billy B.,
2 Parkdale Plaza, Corpus Christi.
Danford, Edwin A., 712 Booty, Corpus Christi.
Davis, Walter T.,
517 Clifford St., Corpus Christi.
Dixon, Chalmer D., Box 109, Corpus Christi.
Dolch, Stanley F. N., Jr.,
4206 Ayers St., Corpus Christi.
Draper, Leonidas M.,
207 Wilson Bldg., Corpus Christi.
Eberle, Howard J.,
202 Med.-Dental Bldg., Corpus Christi.
Eckhardt, Kleberg,
3832 Denver, Corpus Christi.
Edwards, Thos. W.,
244 Oleander St., Corpus Christi.
Ellis, Frank A. (Inac.),
611 Blucher, Corpus Christi.
Engel, Kenneth J.,
2540 Morgan Ave., Corpus Christi.
Etheridge, John M.,
1611 Fifth St., Corpus Christi.
Feerer, Donald J.,
2 Parkdale Plaza, Corpus Christi.
Fitzgerald, Thomas F.,
1001 Louisiana, Corpus Christi.
Fordtran, Robert L., (Mil.),
4338 Yucca St., Corpus Christi.
Frank, Thelma E.,
1314 16th St., Corpus Christi.
Fraser, David B., 1611 5th St., Corpus Christi.
Frich, Michael C.,
525 Everhart Rd., Corpus Christi.
Friedman, Bernard B.,
916 Jones Bldg., Corpus Christi.
Furman, McIver, Furman Bldg., Corpus Christi.
Gabbard, James G.,
1001 Louisiana, Corpus Christi.
Garcia, Clotilde P.,
3838 Baldwin St., Corpus Christi.
Garcia, Hector P.,
3024 Morgan, Corpus Christi.
Garcia, Jose A., 1101 19th St., Corpus Christi.
Gardner, Joseph E.,
1214 Santa Fe, Corpus Christi.
Garrett, Leslie M.,
2850 Topeka, Corpus Christi.
Gentry, William H. (Hon.),
1726 Second St., Corpus Christi.
Ghormley, William C.,
615 Oliver Courts, Corpus Christi.
Giles, E. Jackson, 2442 Morgan, Corpus Christi.
Gill, E. King, 2414 Morgan, Corpus Christi.
Glanz, Sanford, 2435 Morgan, Corpus Christi.
Goodman, Paul H.,
1214 Santa Fe, Corpus Christi.
Gray, Paul M., 2420 Morgan, Corpus Christi.
Griffin, Harold E. (Pres.),
308 Med. Arts Bldg., Corpus Christi.
Groner, Edwin Ben,
533 Gordon, Corpus Christi.
Grossman, Bernard B.,
1001 Louisiana, Corpus Christi.
Grossman, David N.,
Commerce Bldg., Corpus Christi.
Grossman, Maurice S.,
2425 Morgan Ave., Corpus Christi.
Grossman, Saul, 2530 Morgan, Corpus Christi
Guttman, L. Paul 1626 10th St., Corpus Christi.
Guttman, Paul B.,
1626 10th St., Corpus Christi.
Gwin, H. Shannon B.,
407 Med. Arts Bldg., Corpus Christi.
Hamilton, Doyne B., Robstown.
Hartwick, Fred W.,
1222 S. Staples, Corpus Christi.
Haynes, Henry M., Jr.,
2418 Morgan, Corpus Christi.
Heaney, H. Gordon,
1300 3rd St., Corpus Christi.
Heaney, Kathryn,
2709 Swantner, Corpus Christi.
Heymann, Hans E.,
2709 Swantner Dr., Corpus Christi.
Hoffpauir, Alvin C.,
Med. Prof. Bldg., Corpus Christi.
Holt, Everett L.,
3840 Lexington, Corpus Christi.
House, Rex C., 2455 Morgan, Corpus Christi.
Howze, Jo W., (Mil.), Robstown.
Hubler, Winthrope R.,
1510 S. Brownlee, Corpus Christi.
Hudson, George C.,
1630 S. Brownlee, Corpus Christi.
Hudson, Richard L.,
531 Gordon, Corpus Christi.
Hyder, Prentiss L.,
2429 Morgan St., Corpus Christi.
Janssen, L. W. O. Jr.,
2444 Morgan, Corpus Christi.
Jasperson, Clarence P.,
1326 Santa Fe, Corpus Christi.
Jimenez, Prospero, Jr.,
2554 Morgan, Corpus Christi.
Johnson, Robert W.,
1209 Santa Fe, Corpus Christi.
Jones, John M., 2514 Morgan, Corpus Christi.
Juarez, Reyna Guillermo,
2731 Morgan St., Corpus Christi.
Kendrick, Michael C.,
2437 Morgan, Corpus Christi.
Kennedy, Hugh A.,
204 Med.-Dental Bldg., Corpus Christi.
Kiel, Alois F.,
1630 S. Brownlee, Corpus Christi.
Klotz, Joseph G.,
2416 Morgan, Corpus Christi.
Knapp, Roger S., 621 Ohio St., Corpus Christi.
Koepsel, Orlando S.,
2454 Morgan Ave., Corpus Christi.
Kohlhaas, Bernice K.,
417 Miramar Place, Corpus Christi.
Kohlhaas, John K.,
417 Miramar Place, Corpus Christi.
Kurzner, Meyer, 712 Booty, Corpus Christi.
Landesman, Joseph D.,
1234 3rd St., Corpus Christi.
Lane, Alfred L.,
1001 Louisiana, Corpus Christi.
Lang, Rudolph R.,
1001 Louisiana, Corpus Christi.
Lemke, Walter M.,
2522 Morgan, Corpus Christi.
Lingenfelder, John,
1920 S. Staples, Corpus Christi.
Little, C. R., 1001 Louisiana, Corpus Christi.
Maloney, Vance J., Jr.,
2422 Morgan St., Corpus Christi.
Mann, Nathan,
1806 S. Alameda, Corpus Christi.
Marler, Otis E.,
3216 Reid Drive, Corpus Christi.
Martin, Sterling B.,
1713 S. Brownlee, Corpus Christi.

McCaskey, Gregory M.,
1001 Louisiana, Corpus Christi.
McCaskey, Mary M.,
1001 Louisiana, Corpus Christi.
McKemie, Jack F., 527 Gordon, Corpus Christi.
McKenzie, Charles E.,
P. O. Box 3151, Corpus Christi.
Mella, Charles A.,
3216 Reid Dr., Corpus Christi.
Metzger, William R.,
2840 S. Alameda, Corpus Christi.
Moller, G. Turner,
2532 Morgan, Corpus Christi.
Moody, Foy H., 1611 Fifth St., Corpus Christi.
Moon, Orville B., Jr.,
225 Med.-Dental Bldg., Corpus Christi.
Moran, J. Patrick,
209 Med.-Dental Bldg., Corpus Christi.
Morgan, Chas. G., Jr.,
156 Santa Barbara, Corpus Christi.
Morphew, Raymond L.,
1001 Louisiana, Corpus Christi.
Morris, William E.,
1546 S. Brownlee, Corpus Christi.
Nast, Jerome, 1126 Third St., Corpus Christi.
Nast, Maurice D., 1126 3rd St., Corpus Christi.
Neubauer, Dorothea E.,
Rt. 4, Box 78, Corpus Christi.
O'Brien, Thomas P.,
1001 Louisiana, Corpus Christi.
Oshman, Joseph, 1010 Ohio, Corpus Christi.
Padilla, Arthur,
415 Commerce Bldg., Corpus Christi.
Pasternack, Joseph G.,
1001 Louisiana St., Corpus Christi.
Perkins, Maury J.,
2415 Morgan Ave., Corpus Christi.
Phelps, Travis B.,
1546 S. Brownlee, Corpus Christi.
Pilcher, John F.,
P. O. Box 5416, Corpus Christi.
Posner, Sidney, Robstown.
Powell, Sam M., 301 Palmero, Corpus Christi.
Priday, Cedric, 934 Ayers, Corpus Christi.
Pruessner, Harold T.,
3840 Lexington Blvd., Corpus Christi.
Ray, Richard H., 3727 Lincoln, Corpus Christi.
Reeves, Gerald A.,
1546 S. Brownlee, Corpus Christi.
Reilly, William D.,
1238 Fifth St., Corpus Christi.
Riley, James R., 2400 Morgan, Corpus Christi.
Riley, Winston E.,
2400 Morgan, Corpus Christi.
Rinehart, Archie B.,
913 S. Port, Corpus Christi.
Rogers, Frederick F.,
1001 Louisiana, Corpus Christi.
Roosth, Hyman P.,
2421 Morgan, Corpus Christi.
Rosenheim, Philipp,
2472 Morgan, Corpus Christi.
Russo, G. Martin.
2512 Med. Center, Corpus Christi.
Schuster, George III,
2427 Morgan, Corpus Christi.
Segrest, John B.,
3218 Olson Drive, Corpus Christi.
Sharp, James C., 2456 Morgan, Corpus Christi.
Shields, William A., Jr.,
2709 Swantner Dr., Corpus Christi.
Sierra, Ernesto, 2735 Morgan, Corpus Christi.
Sigler, Robert J.,
P. O. Box 5212, Corpus Christi.
Sisson, James H., Box 5416, Corpus Christi.
Slabaugh, Carlyle B.,
1733 S. Brownlee, Corpus Christi.
Sloan, John J., 2432 Morgan, Corpus Christi.
Sloan, Joseph M.,
P. O. Box 6038, Corpus Christi.
Smith, Youel C., Jr.,
1001 Louisiana, Corpus Christi.
Smith, Youel C., Sr.,
1630 S. Brownlee, Corpus Christi.
Sory, Crysup,
1546 S. Brownlee, Corpus Christi.
Spann, R. Gayle,
1546 Brownlee, Corpus Christi.
St. John, Ralph V.,
1001 Louisiana, Corpus Christi.
Stephen, J. J., P. O. Box 231, Robstown.
Stewart, Chas. D.,
1001 Louisiana, Corpus Christi.
Stone, Belo, Robstown.
Stroud, S. K.,
Med.-Dental Bldg., Corpus Christi.
Swearingen, Robert G.,
1002 Ohio St., Corpus Christi.
Tabler, J. Walton,
1002 Ohio St., Corpus Christi.
Talley, Oran H.,
3701 S. Saxet Dr., Corpus Christi.
Thomas, James H.,
1546 S. Brownlee, Corpus Christi.
Thomas, John R. (Inac.),
702 Morgan, Corpus Christi.
Thomas, Rex E.,
1546 S. Brownlee, Corpus Christi.
Thomason, Elizabeth C.,
3364 Manitou, Corpus Christi.
Thomason, Robert H.,
2467 Morgan St., Corpus Christi.
Triplett, William C.,
234 Med.-Dental Bldg., Corpus Christi.
Tyree, James I., 1209 Santa Fe, Corpus Christi.
Upshaw, Bette Y. (Inac.),
430 Catalina, Corpus Christi.
Upshaw, Jackson E.,
1017 Santa Fe, Corpus Christi.
Veatch, Donald Hugh,
2466 Morgan Ave., Corpus Christi.
Ware, Stephen H., Jr.,
908 Ayers, Corpus Christi.
Watson, Clyde O.,
616 Jones Bldg., Corpus Christi.
Weregrove, John F.,
2514 Morgan St., Corpus Christi.
White, Hosea A. (Inac.),
412 King St., Corpus Christi.
Wilkens, Robert,
2473 Morgan, Corpus Christi.
Williams, Minor L. (Hon.), Robstown.
Williams, Stephen A.,
319 Furman Bldg., Corpus Christi.
Williford, E. Allan,
1546 S. Brownlee, Corpus Christi.
Wood, Robert C.,
1401 Santa Fe, Corpus Christi.
Woods, Haddon B.,
1335 Third St., Corpus Christi.
Woods, Helen H.,
2526 Med. Center, Corpus Christi.
Woods, Richard R.,
2526 Med. Center, Corpus Christi.
Woody, Hannah B.,
515 Elizabeth, Corpus Christi.
Woody, Norman C.,
515 Elizabeth, Corpus Christi.
Wright, L. David,
1546 S. Brownlee, Corpus Christi.
Yates, June, Med. Prof. Bldg., Corpus Christi.
Yeager, Charles P. (Hon.),
408 Wilson Bldg., Corpus Christi.
Yeager, Franklin W.,
408 Wilson Bldg., Corpus Christi.
York, Thomas L., 4206 Ayers, Corpus Christi.
Zinke, Erhardt,
3218 S. Port Ave., Corpus Christi.

SAN PATRICIO-ARANSAS-REFUGIO

Baen, Daniel R. (Pres.), Mathis.
Connolly, John V. (Sec'y),
Box 787, Ingleside.
Curlee, Curtis L., Sinton.
Deitch, Ernest R., 501 W. Market, Sinton.
Dickinson, Rodger C., Box 1026, Ingleside.
Elliott, Boyce, Aransas Pass.
Ewing, F. Stanley, Sinton.
Finn, John H., Refugio.
Gilmore, Robert M., Portland.
Guynes, William A., Mathis.
Heard, Richard H., Zarsky Bldg., Refugio.
Jenkins, Young S., 701 Fetick St., Taft.
Koontz, Arch C., Woodsboro.
McConchie, Richard D., Aransas Pass.
Meitzen, Travis C., Refugio.
Miller, Harry A., Refugio.
Pierce, James L., Jr., Box 271, Sinton.
Rittiman, Melross C.,
Ewing Mem. Hosp., Sinton.
Selby, Claude A., P. O. Box 876, Sinton.
Shelton, Josephine A., Refugio.
Simpson, Charles H.,
501 W. Market St., Sinton.
Tasch, A. F., 717 Field St., Taft.
Tunnell, John W., Taft.
Tunnell, Rose N., Taft.
Voss, Alpheus H., Odem.
Wood, Lloyd G., Rockport.
Zaccaria, Attilio, Jr., Portland.
Zarsky, Emil P., Refugio.

WEBB-ZAPATA-JIM HOGG

Baker, Julia M.,
Campos Eliseos 15, Mexico City 5, D. F.
Canseco, Francisco M.,
Sames Moore Bldg., Laredo.
Chapa-Badillo, Jesus,
216 Matamoros St., Laredo.
Cigarroa, J. G., Jr., 708 Matamoros, Laredo.
Cigarroa, J. Gonzalez, 708 Matamoros, Laredo.
Cigarroa, L. Gonzalez (Sec'y),
806 Matamoros, Laredo.
Cigarroa, Margaret G.,
Sames Moore Bldg., Laredo.
Cook, Albert T. (Hon.), Zapata.
Crawford, James L. (Hon.),
1701 Rosario St., Laredo.
De La Garza, Raul, Moore Bldg., Laredo.
Graham, Stephen H., Jr., M & S Clinic, Laredo.
Guerra, M. Barrera, Hebbronville.
King, Albert C., 801 Matamoros, Laredo.
Longoria, Enrique M.,
Sames Moore Bldg., Laredo.
Lowry, John T., Lowry Clinic, Laredo.
Lowry, Ruby S., Sames Moore Bldg., Laredo.
Malakoff, Morris E., (Pres.),
806 Matamoros, Laredo.
Mata, Juan Jose, Valls Clinic, Laredo.
Montalvo, Lauro,
1605 Washington St., Laredo.
Musacchio, Frederick A.,
1011 Hidalgo St., Laredo.
Penny, George E., 801 Matamoros, Laredo.
Powell, Paul H., Jr., 801 Matamoros, Laredo.
Powell, William R., 801 Matamoros, Laredo.
Puig, Valentine L., Jr.,
801 Matamoros, Laredo.
Reitman, James S., 1820 Guerrero, Laredo.
Rottenstein, Max,
Sames Moore Bldg., Laredo.
Trevino, Enrique G., 812 Matamoros, Laredo.
Valls, Miguel, 1004 San Bernardo, Laredo.
Wright, Ray B. (Hon.),
914 Hidalgo St., Laredo.

SEVENTH DISTRICT

Dr. David Wade, Austin, Councilor

BASTROP-LEE

Burns, Robert B., Giddings.
Goddard, Chauncey G., Bastrop.
Hardt, Sterling M., 1109 Church St., Bastrop.
Hazzard, Alford R. (Sec'y),
513 E. Austin St., Giddings.
Loveless, Robert W., Box N, Bastrop.
Mantzel, Sherwood W. (Pres.),
Box 187, Giddings.
Morris, Roy H., Jr., Fleming Hosp., Elgin.
Reedy, Thomas M., Elgin.
Stephens, J. D. Box 817, Smithville.
Thomas, James W., P. O. Box 747, Smithville.
Vickers, Albert F., 513 E. Austin St., Giddings.
Weishuhn, Francis J., 302 Olive St., Smithville.
Wood, William E. (Inac.),
1010 N. Main St., Elgin.
York, William E. (Hon.), Giddings.

CALDWELL

DuBoise, Otho K., Lockhart.
Fielder, Darwin L., Lockhart.
Luckett, Francis C., Box 13, Fentress.
Nichols, H. Clay, Drawer 111, Luling.
O'Banion, J. Turner,
880 S. Magnolia Ave., Luling.
Playfair, James H., 516 E. Pierce, Luling.
Robertson, Wm. G., Jr. (Pres.),
508 E. Pierce, Luling.
Ross, Abner A., 214 W. San Antonio, Lockhart.
Wales, Philip A. (Sec'y),
214 W. San Antonio, Lockhart.

HAYS-BLANCO

Bullard, Ray E., Jr., Box 346, Blanco.
deSteiguer, John R., (Hon.), (Dead).
Elliott, Benge, (Sec'y.),
222 W. Hopkins, San Marcos.
Heatly, Maurice D., Box 25, San Marcos.
McCormick, T. Charles, Jr., Buda.
Moore, William L., Jr.,
404 N. Guadalupe, San Marcos.
Scheib, Charles W., P. O. Box 11, San Marcos.
Sowell, Rugel F.,
302 W. San Antonio, San Marcos.
Sowell, Rugel F., Jr., Box 76, San Marcos.
Van Ness, Julius M. (Hon.), San Marcos.
White, David L. (Pres.), San Marcos.
Williams, Milton C. (Hon.), San Marcos.

LAMPASAS-BURNET-LLANO

Allen, George S., 410 S. Water St., Burnet.
Brook, Winston M., Box 786, Lampasas.
Carroll, Donald W. (Pres.),
209 East 3rd St., Lampasas.
Dansby, Garland L., Llano.
Duffy, Jack G., (Int.),
5130 Carew St., Houston.
Gardner, Ralph E., Bertram Hosp., Bertram.
Gray, George L. (Hon.), Llano.
Hoerster, Dan J., 110 Main St., Llano.
Hoerster, Henry J., Llano.
Landrum, Marvin M. (Hon.), Lampasas.
McMillin, D. Rush, Lampasas.
Newman, Peggy Jo (Sec'y),
Box 128, Burnet.
Ozier, Billy B., 410 S. Water St., Burnet.
Patteson, Morris K., Lampasas.
Shepperd, Joe A., Box 128, Burnet.

Shepperd, Ray L., Box 128, Burnet.
Shepperd, W. Ivan, Marble Falls.
Vaughan, Thomas D. (Inac.), Bertram.
Wood, Alonzo C., Jr., Marble Falls.

TRAVIS

Allison, Bruce (Inac.),
5121 Pershing Ave., Fort Worth.
Archer, John Dale,
U. of Tex. Health Center, Austin.
Archer, Thos. J., Jr.,
3203 Meredith St., Austin.
Auler, Hugo (Inac.), 4701 Crestway, Austin.
Bachtel, May B., Student Health Center, Austin.
Bacon, Dan W. (Mil.),
280 Childress St., Wichita Falls.
Baggett, Seldon O., 7 Med. Arts Square, Austin.
Bailey, Charles W., Scarbrough Bldg., Austin.
Bailey, Joe W., 502 W. 15th St., Austin.
Bain, Ruth M. (Sec'y),
1805 Nueces St., Austin.
Barker, Paul W., 1103 Nueces, Austin.
Barkley, Douglas F., 1702 N. Congress, Austin.
Bates, B. Clary, 1108 Nueces, Austin.
Bendel, Henry W., Jr., (Int.),
V. A. Hosp., McKinney.
Bethea, James A. (Inac.),
116 Tower Drive, San Antonio.
Blackstock, Mathis W.,
4708 Burnet Rd., Austin.
Blaustone, Henry H. (Int.),
1606 Pearl St., Austin.
Blewett, Emerson K.,
13 Med. Arts Square, Austin.
Bohls, Sidney W., 803 E. 32nd St., Austin.
Boston, John A., Jr., 412 W. 17th St., Austin.
Brady, J. J., 1705 Colorado, Austin.
Brandt, Otto, Jr., 1506 Guadalupe, Austin.
Bratton, Robert E., 1606 Poquonack, Austin.
Brown, M. I.,
209 Capital Natl. Bk. Bldg., Austin.
Brownlee, Charles H. (Inac.),
603 W. 14th St., Austin.
Brumage, Wm. S., State Health Dept., Austin.
Carter, C. E., 603 Carolyn, Austin.
Carter, Rexford G., 1709 San Antonio, Austin.
Chambers, Rawley E.,
Box 5, Capitol Sta., Austin.
Chauvin, E. V., 807 Scarbrough Bldg., Austin.
Clark, George E., Jr.,
1 Med. Arts Square, Austin.
Cleveland, G. W., 1209 Parkway, Austin.
Cloud, Ralph E. (Inac.),
48 Summit View, Austin.
Cochran, William E., 5811 Burnet Rd., Austin.
Coleman, James M., 108 W. 30th St., Austin.
Colwell, Leslie C., 1110 Nueces St., Austin.
Conner, Beadie E.,
1415 Rosewood Ave., Austin.
Cooper, R. Allwyn, 924 East 32nd St., Austin.
Covert, Frank M., III, 2903 Red River, Austin.
Crockett, John A., Univ. Health Center, Austin.
Cromer, Horace E.,
605 Capital Natl. Bk. Bldg., Austin.
Crowell, Caroline, Univ. of Texas, Austin.
Darnall, Charles M.,
605 Cap. Natl. Bank Bldg., Austin.
Darnall, Joseph R. (Inac.),
3209 Duval St., Austin.
Davidson, Harry T., 1403 Rio Grande, Austin.
Davidson, Morris (Inac.), Austin.
Dawson, George A. (Mil.),
4021st USAF Hosp., Dyess AFB, Abilene.
Dildy, Charles B., 504 W. 17th St., Austin.
Doles, Emmett A.,
704 Cap. Natl. Bank Bldg., Austin.
Douglas, John E., 1403 San Antonio, Austin.
Dryden, Sam H., 1302 Sabine, Austin.
DuBilier, Ben. 528 Capital Natl., Austin.
Dunkelberg, Walter R. (Int.),
Austin State Hosp., Austin.
Dunlop, Josephine N. (Inac.),
108 W. 15th St., Austin.
Eckhardt, James W., 512 Capital Natl., Austin.
Edens, Lee E.,
522 Cap. Natl. Bank Bldg., Austin.
Eppright, Ben R., Capital Natl., Austin.
Esquivel, Sandi, 1306 Rio Grande, Austin.
Exline, Albert L., 505 W. 15th St., Austin.
Fatter, Mervin E., 500 W. 15th St., Austin.
Faubion, Darrell B., 2901 Red River, Austin.
Ferrin, Charles E., 1605 S. Lamar Blvd., Austin.
Forbes, M. Allen, Jr., 607 W. 14th St., Austin.
Fox, Kermit W., 1010 W. 19th St., Austin.
Garcia, Albert G., 209½ E. 6th St., Austin.
Garcia, John A., 209½ E. 6th St., Austin.
Gauntt, W. Charles, 811 Nueces, Austin.
Gentry, M. Elizabeth,
2209 Quarry Road, Austin.
Giesen, Andrew F., Jr.,
2410 Rio Grande, Austin.
Gilbert, Joe T., 918 E. 32nd St., Austin.
Glynn, James D., 707 W. 19th St., Austin.
Goehrs, Homer R., 503 West 15th St., Austin.
Graham, James M., 1504 Guadalupe, Austin.
Gregg, F. Banner, 119 Perry Brooks, Austin.
Griffin, Lawrence L., 1010 W. 19th St., Austin.
Haan, George W., 3001 Perry Lane, Austin.
Hahn, William B., 1506 Guadalupe, Austin.
Halden, William J.,
1313 Westover Rd., Austin.
Hall, William Larkin,
4808 Lansing Dr., Austin.
Hamer, James G., 4015 Guadalupe, Austin.
Hanes, Lisburn C. (Mil.), Austin.
Hanna, Ralph, 108 W. 30th St., Austin.
Hanna, Roger J.,
321 Bailey, East Lansing, Mich.
Hardwicke, Charles P., 918 E. 32nd, Austin.
Harris, Forrest D. (Int.), 1313 Sabine, Austin.
Harris, Woodson W.,
126-B East Oltorf, Austin.
Haslund, Thomas M., 811 E. 31st St., Austin.
Hayes, Sigman W., 4708 Burnet Road, Austin.
Heitzman, Celine I. C.,
2600 E. 19th St., Austin.
Helm, Fred P.,
Texas State Dept. of Health, Austin.
Henry, Harvey B., 1205 Nueces, Austin.
Herrod, James H.,
13 Medical Arts Square, Austin.
Hilgartner, Henry L., Jr.,
202 W. 13th St., Austin.
Hoerster, Samuel A., Jr., Box 96, Austin.
Holland, Lang F., 505 W. 13th St., Austin.
Holle, Henry A.,
State Health Department, Austin.
Holtz, Harvey E.,
17 Medical Arts Square, Austin.
Hunter, Richard O.,
1512½ S. Congress, Austin.
Jacobs, Maurice, 1309 Nueces, Austin.
Johnson, Billy Frank,
7 Med. Arts Square, Austin.
Johnson, David O., 2901 Red River, Austin.
Johnson, J. Edward,
401 Scarbrough Bldg., Austin.
Karn, Willard R. (Int.)
Box 117, Oakridge, Tenn.
Kelly, Alfred J., 6009A Burnet Rd., Austin.
Kelton, William W., Jr.,
108 W. 30th St., Austin.
Key, Sam N., Jr., 120 W. 7th St., Austin.
King, William C., 607 W. 14th St., Austin.
Klint, Hugo A., 1805 Nueces St., Austin.
Klotz, H. L., 2200 Griswold, Austin.
Kluth, Fred C.,
State Dept. of Health, Austin.
Kreisle, James E., Box 5135, Austin.
Kreisle, Matthew F., Box 5135, Austin.
Kreisle, Matthew F., Jr., Box 5135, Austin.
LaLonde, Albert A.,
Cap. Natl. Bank Bldg., Austin.
Lane, Richard P. (Mil.),
U. S. Army Disp., Ft. Bliss.
Lassiter, James W., 2901 Red River, Austin.
Lawlis, Virgil B., 1304 Fairwood Dr., Austin.
Lawson, Joseph H., Brackenridge Hosp., Austin.
Legett, Carey, Jr., 1707 Colorado, Austin.
Legett, Georgia F., 1707 Colorado, Austin.
Legett, Martin P., 3717 East Ave., Austin.
Lippmann, Otto, 405 West 15th, Austin.
Long, Carolyn J., 1008 East 11th St., Austin.
Long, Walter K., 503 W. 15th St., Austin.
Lowry, Frederick C.,
6 Med. Arts Square, Austin.
Lucas, Richard A., 502 W. 13th St., Austin.
Martin, Claud A., 1301 Rio Grande, Austin.
Martin, Frances G. (Int.),
56 Pen Haven Dr., Pensacola, Fla.
Martin, Lawrence W., (Mil.),
56 Pen Haven Dr., Pensacola, Fla.
McCauley, Morris D.,
1506-A Guadalupe, Austin.
McCormick, Katharine,
Univ. Health Center, Austin.
McCoy, Buster Eugene (Int.),
1702 Giles St., Austin.
McCuistion, C. Hal,
609 Cap. Natl. Bank Bldg., Austin.
McElhenney, Thomas J.,
1402 Nueces St., Austin.
McLean, William F., 502 W. 13th St., Austin.
McShane, Patrick I.,
Box S, Capitol Station, Austin.
Miears, Claude H., Scarbrough Bldg., Austin.
Miller, Clarence R., P. O. Box 96, Austin.
Milligan, Barth, 4616 Red River, Austin.
Moore, Carl F., Jr., 412 E. 5th St., Austin.
Moore, Walter S., 5718 Burnet Rd., Austin.
Morgan, William P.,
Capital Natl. Bank Bldg., Austin.
Morris, Truman N.,
13 Med. Arts Square, Austin.
Morrison, Robert B.,
801 Capital Natl. Bank Bldg., Austin.
Murray, R. Vincent, Jr.,
Capital Natl. Bank Bldg., Austin.
Nanney, Audie L.,
406 Capital Natl. Bank Bldg., Austin.
Neighbors, Allen H. (Inac.),
1801 Lavaca, Austin.
Neighbors, Allen H., Jr.,
926 East 32nd, Austin.
Nelson, F. Murphy, 2 Med. Arts Square, Austin.
Newman, Henry W. (Inac.),
2710 San Pedro, Austin.
Paggi, Leonard C., 404A W. 15th St., Austin.
Pape, Robert W. (Int.), Box 71, Yoakum.
Paris, P. J., 811 Littlefield Bldg., Austin.
Paterson, Elizabeth A.,
2614 Delwood Place, Austin.
Pattillo, Albert D.,
510 Capital Natl. Bank Bldg., Austin.
Paulsen, Paul F. Jr., 2913 Red River, Austin.
Pearce, Francis M., Jr.,
605 Capital Natl. Bank Bldg., Austin.
Peavy, Charles D., 806 Littlefield, Austin.
Pelphrey, Charles F.,
8 Med. Arts Square, Austin.
Phillips, Joseph T., Tribune Bldg., Austin.
Pohl, Donald E.,
1 Med. Arts Square, Austin.
Polsky, Morris, 1503 Guadalupe, Austin.
Prewett, J. Edwards, 1000 Lavaca, Austin.
Price, Pinckney Clift, 108 W. 30th St., Austin.
Price, Thomas G.,
8 Med. Arts Square, Austin.
Primer, B. M., Jr. (Mil.), Austin.
Primer, Benjamin M., Sr.,
2709 Rio Grande, Austin.
Rabb, Virgil S., Star Rt. A, Box 1, Austin.
Rainey, John R., Jr.,
8 Med. Arts Square, Austin.
Ravel, Jerome O., 1103B Nueces St., Austin.
Reifslager, Walter E.,
1120B West 19th St., Austin.
Reinarz, B. H., 511 W. 15th St., Austin.
Renfert, Henry, Jr., 705 Capital Natl., Austin.
Roberts, Walter D.,
20 Med. Arts Square, Austin.
Robinson, Harold L., 801 West Ave., Austin.
Robison, James T., Capital Natl., Austin.
Ross, Raleigh R. (Pres.),
2 Med. Arts Square, Austin.
Rothen, Robert M., 502 W. 13th St., Austin.
Rousos, Anthony P., 528 Capital Natl., Austin.
Rude, Joe C., Brackenridge Hosp., Austin.
Runge, Thomas M.,
712 Capital Natl Bank Bldg., Austin.
Salmon, Watt T. (Int.),
Winter V. A. Hosp., Topeka, Kans.
Sanders, John Nelson, 1309 Nueces, Austin.
Sayers, Leonard J.,
705 Capital Natl. Bank Bldg., Austin.
Scarborough, Lee F., 926 E. 32nd St., Austin.
Schiller, Nelson L., 515 W. 15th St., Austin.
Schoch, Eugene P., Jr., 117 W. 7th St., Austin.
Scott, H. A., 1302 Sabine, Austin.
Scott, Z. T. (Hon.),
2408 Sweetbrush Dr., Austin.
Sedberry, Margaret M.,
Austin State Hosp., Austin.
Sedberry, Miles E., Jr.,
108 W. 30th St., Austin.
Senter, Jerald R., 1710 N. Congress, Austin.
Simms, Benjamin F., 2905 Red River, Austin.
Smart, V. C., Jr., 1400 East Avenue, Austin.
Smith, Howard E., 410 E. 5th St., Austin.
Snider, Robert N., 2410 Rio Grande, Austin.
Sousares, Teddy M.,
1906 Karen Avenue, Austin.
Stahl, Marion L., 1213 B Parkway, Austin.
Stenberg, Robert T.,
Austin State Hosp., Austin.
Suehs, Oliver W.,
14 Med. Arts Square, Austin.
Swearingen, R. O.,
2 Med. Arts Square, Austin.
Terry, A. A., 918 E. 32nd St., Austin.
Thomas, John F., 918 E. 32nd St., Austin.
Thompson, Burch, 2104 Sabine, Austin.
Thorne, G. Clifford,
12 Med. Arts Square, Austin.
Thorne, Lansing S.,
12 Med. Arts Square, Austin.
Thorne, Milner S., 2901 Red River, Austin.
Tipton, George W., 502 W. 15th St., Austin.
Tisdale, Albert A.,
20 Med. Arts Square, Austin.
Tisdale, Alice M. C.,
4205 Caswell Ave., Austin.
Todaro, Samuel P.,
1705 Congress Ave., Austin.
Turner, Milton, 1015 E. 32nd St., Austin.
Umstattd, Robert G., 2901 Red River, Austin.
Wade, David,
510 Capital Natl. Bank Bldg., Austin.
Walter, Luther P., 3212 Meredith, Austin.
Watkins, W. Pruett, 3313 Hancock Dr., Austin.
Watt, Terrence N.,
304 Capital Natl. Bank Bldg., Austin.
Watt, Will E.,
508 Capital Natl. Bank Bldg., Austin.
Weaver, John Dale, 600 W. 11th St., Austin.

Wharton, Lawrence H.,
602 West 12th St., Austin.
White, B. O., 1707 Nueces St., Austin.
White, Paul L.,
Health Dept., Texas U., Austin.
Wilborn, Sam W.,
12 Med. Arts Square, Austin.
Wilks, William N., (Int.),
113 Roosevelt, Topeka, Kans.
Williams, Harold L.,
7 Med. Arts Square, Austin.
Williams, Harold M.,
711 West 14th St., Austin.
Williams, Harriss,
Capital Natl. Bank Bldg., Austin.
Wilson, William L.,
State Health Dept., Austin.
Winkler, John J., 5623 Shoal Creek, Austin.
Womack, David R., 3415 Spanish Oak, Austin.
Woodson, B. Palmer, Scarbrough Bldg., Austin.
Wooten, Greenwood S.,
107 E. 10th St., Austin.
Yeakel, Earl L., Jr., 2901 Red River, Austin.
Yerwood, Connie R., 410 East Fifth, Austin.
Zedler, Garland G., 603 W. 15th St., Austin.
Zidd, Edward, 403 W. 15th St., Austin.

WILLIAMSON

Alexander, Margaret H., 720 Talbot, Taylor.
Benold, Douglas M. (Pres.),
715 Main, Georgetown.
Clearman, Ralph E., P. O. Box 488, Granger.
Cooper, Dewey H., Georgetown.
Daniel, Crawford J., 720 W. 6th St., Taylor.
Gaddy, Howell R., Jr. (Sec'y),
605 E. 12th St., Georgetown.
Gregg, Dick B., Round Rock.
Hermann, Robert C., 813 N. Main, Taylor.
Johns, Jay J., 720 W. 6th St., Taylor.
Kirkpatrick, B. A., Taylor.
Kirkpatrick, Roy H., Taylor.
Lehmberg, Seth W., Taylor.
Leshikar, Marvin J., 720 W. 6th St., Taylor.
Lindsey, David C., V. A. Hospital, McKinney.
Martin, John R., Georgetown.
Miller, C. R., Box 26, Leander.
Rice, Albert J.,
516 Chesterton Ave., Belmont, Calif.
Stromberg, Eric W., Taylor.
Swanson, Wayland R., 800 W. 7th St., Taylor.
Wedemeyer, Wm. C., Route 3, Georgetown.

EIGHTH DISTRICT

Dr. Carlos E. Fuste, Jr., Alvin, Councilor

BRAZORIA

Brown, G. Bedford, Jr.,
432 Mulberry St., Angleton.
Caldwell, John S., Jr.,
Brazosport Clinic, Velasco.
Carlton, B. Hardy, 326 W. Broad, Freeport.
Carroll, Gay V., Box 26, Lake Jackson.
Chapman, Lawrence E., Jr.,
432 E. Mulberry St., Angleton.
Coleman, Catherine E.,
Brazoria County Health Dept., Angleton.
Cook, T. Edwin, Dow Hospital, Freeport.
Davis, Wallace Rex,
P. O. Box O, West Columbia.
Fisher, James A., Jr.,
1407 West 10th, Freeport.
Flake, Raymond E., Jr.,
Dow Chemical Co., Freeport.
Fuste, Carlos E., Jr., 907 Gordon, Alvin.
Galloway, William T.,
304 West Broad, Freeport.
Gray, Ralph E., 819 Gulf Blvd., Velasco.
Greenwood, William M., West Columbia.
Hardwick, M. Warren,
839 E. Mulberry, Angleton.
Hayes, Granville J., Alvin.
Heimbigner, Elmer, 152 Oak Dr., Lake Jackson.
Hester, Fletcher, 409 Main St., Sweeny.
Holt, William C., Box 937, Angleton.
Jamar, Robert S., Jr., 401 Foley, Alvin.
Johnson, Oscar L., Jr.,
229 Parking Way, Lake Jackson.
Kilian, Duane Jack (Sec'y),
Dow Chemical Co., Freeport.
Lee, William M., 815 Hardie St., Alvin.
Mallerich, Melvin J.,
2409 Shakespeare, Houston.
Marshall, John E., 110 Primrose, Lake Jackson.
May, Henry K.,
229 Parking Way, Lake Jackson.
McCary, A. O'Brien,
304 W. Broad St., Freeport.
McCary, Rogers M.,
304 West Broad, Freeport.
McDonald, Richard,
P. O. Box 97, Lake Jackson.
Merz, Herbert E., 815 Hardie, Alvin.
Miller, Robert C., Box J, Lake Jackson.
Montgomery, Joe S., Jr., Box 937, Angleton.
Moore, John M., Jr., Brazoria.
Nicholson, William D.,
304 W. Broad, Freeport.
Perryman, Gerald F., Dow Hospital, Freeport.
Rau, James R., Box 454, Pearland.
Ritch, Thomas A., 304 W. Broad, Freeport.
Sanders, Dorris A., Sweeny.
Skinner, William T.,
101 Parking Way, Lake Jackson.
Smith, Mary L. (Int.),
9015 Silver Spring La., Houston.
Steele, Wayne K., 933 Mulberry, Angleton.
Stevens, George M.,
101 Parking Way, Lake Jackson.
Stewart, James A. (Pres.),
229 Parking Way, Lake Jackson.
Turner, Frederick C., Box 127, Lake Jackson.
Venable, John R., Dow Chemical Co., Freeport.
Woolf, Martin P. (Int.),
31 Lavender Lane, Levittown, Pa.

COLORADO-FAYETTE

Boelsche, Leslie D., Box 359, La Grange.
Cummins, James E., Weimar.
Fuller, Rex G., Jr., (Sec'y), Box 188, Weimar.
Ihle, Lyman E., Schulenberg.
Laughlin, John R., Eagle Lake.
Laughlin, Jones C., Eagle Lake.
Makinson, James T.,
851 E. Travis St., La Grange.
Mikesky, Walter E.,
715 Lyons St., Schulenberg.
Owen, A. George (Inac.),
Route 1, Fayetteville.
Paine, Henry C., 851 E. Travis, La Grange.
Peters, Leo J., Schulenberg.
Shult, Clarence I., 418 Wallace, Columbus.
Smith, Herbert T.,
442 E. Guadalupe, La Grange.
Thomas, Raymond R., Eagle Lake.
Watzlavick, August J. A.,
P. O. Drawer E, Schulenberg.
Williams, Edward T., La Grange.
Wooten, James H., Jr., Drawer J, Columbus.
Youens, William T. (Pres.), Columbus.
Youens, Willis G., Weimar.
Zatopek, Leland F., 113 Main St., La Grange.

DeWITT

Barth, John H., Yorktown.
Bohman, Alfred J., Cuero.
Burns, John G., Cuero.
Cross, George W. (Hon.), Yorktown.
Davis, John C., 212 E. Morris, Yoakum.
Gohlke, Marvin H., Yorktown.
Hall, Oscar E., Jr. (Sec'y),
106 W. Reuss Blvd., Cuero.
High, Harold R., 510 N. Esplanade, Cuero.
Landry, Luchion B., Cuero.
Mgebroff, A. E., Hubbard St., Yoakum.
Milner, Robert M., Yoakum.
Nau, Carl A.,
U. of Texas Med. Branch, Galveston.
Nowierski, Leon W., Yorktown.
Prather, Frank A., Cuero.
Reuss, Theodore A., 505 N. Esplanade, Cuero.
Richter, Louis B. S., Yoakum.
Trott, John E., 212 E. Morris St., Yoakum.
Westphal, Robert D.,
2002 Holcombe Blvd., Houston.

GALVESTON

Adam, Doris, J. D.,
7705 Plum, New Orleans, La.
Adam, Maurice (Int.),
7705 Plum, New Orleans, La.
Adriance, Carroll T., (Sec'y.),
2402 Sealy, Galveston.
Agnew, Colvin H., 115 Trout, Galveston.
Ainsworth, William H.,
828 Postoffice, Galveston.
Albright, James H., (Int.),
John Sealy Hosp., Galveston.
Allen, Charles R., 928 Strand, Galveston.
Anderson, William T.,
421 South Oak, LaMarque.
Aves, Fred W. (Inac.),
1501 Ave. J, Galveston.
Baird, Elwood E., John Sealy Hosp., Galveston.
Barnes, William C., (Int.),
John Sealy Hosp., Galveston.
Barnett, Herman A. (Int.),
902 Fulton, LaMarque.
Baxter, M. Ruth, 1820 21st St., Galveston.
Baxter, Virgil C., 1820 21st St., Galveston.
Beeler, George W. (Pres.),
Beeler-Manske Clinic, Texas City.
Blacklock, David M., 421 S. Oak, LaMarque.
Blocker, Truman G., Jr.,
Univ. of Texas Med. Branch, Galveston.
Blocker, Virginia I.,
Univ. of Texas Med. Branch, Galveston.
Boelsche, Arr Nell,
John Sealy Hosp., Galveston.
Bromberg, Leon, 1501 Broadway, Galveston.
Brown, G. Wootten, 2402 Sealy, Galveston.
Bruce, E. Ivan, Jr., 1014 Strand, Galveston.
Calma, Victor C.,
Univ. of Texas Med. Branch, Galveston.
Caravageli, M. A.,
506 U. S. Natl. Bank Bldg., Galveston.
Casey, Robert E.,
822 6th St., North, Texas City.
Charpentier, Leonard A.,
22nd & Sealy, Galveston.
Cherry, James H., 1311 Rosenburg, Galveston.
Childers, John H.,
Univ. of Texas Med. Branch, Galveston.
Cochrane, John H., Jr.,
305 Black Oak Ave., LaMarque.
Cooke, Willard R.,
Univ. of Tex. Med. Br., Galveston.
Cooley, Robert N.,
John Sealy Hosp., Galveston.
Cooper, Sidney P., USPHS Hosp., Galveston.
Crass, Gwendolyn,
Univ. of Tex. Med. Br., Galveston.
Danforth, Duncan R.,
820 6th St., N., Texas City.
Davis, Harry K.,
Hwy. 3, at Wilkins, League City.
Delany, John J., 22nd & Sealy, Galveston.
DeMesquita, Paul B.,
2402 Ave. I, Galveston.
Dudney, Newton E.,
Davis-Dudney Clinic, League City.
Duflot, Leo S. M.,
John Sealy Hosp., Galveston.
Dumas, Lawrence W.,
608 Eighth Ave., N., Texas City.
Eames, Daniel H., 525 Hwy. 348, LaMarque.
Earle, Kenneth M.,
133 San Fernando, Galveston.
Eggers, G. W. N., Jr.,
Univ. of Texas Med. Br., Galveston.
Eggers, George W. N.,
2201 Ave. D, Galveston.
Emken, Roy Lee, 622 Hwy. 3, LaMarque.
Evans, Ernest Burke,
Univ. of Texas Med. Br., Galveston.
Felton, Harriet M.,
Univ. of Texas Med. Br., Galveston.
Fisher, William C., (Hon.),
505 S. Prairieville, Athens.
Fleming, Ben P., Box 1108, Texas City.
Ford, G. David, 1501 Broadway, Galveston.
Ford, Hamilton F., John Sealy Hosp., Galveston.
Forman, Sol, 2212 Ave. L, Galveston.
Fowler, M. Lake, Jr.,
4508 Woodrow, Galveston.
Frank, Theo M.,
American Oil Co., Texas City.
Fuchs, Carl J., 519 9th Ave., N., Texas City.
Futch, Edward D.,
611 U. S. Natl. Bk. Bldg., Galveston.
Gambrell, William M., Jr.,
831 5th Ave., N., Texas City.
Garbade, Francis A., 22nd & Sealy, Galveston.
Garber, E. Peter, 1501 Broadway, Galveston.
Gibbs, Reagan H., 1501 Broadway, Galveston.
Ginderske, Monica M., (Int.),
1516 Market St., Galveston.
Gingrich, Wendell D.,
Univ. of Texas Med. Br., Galveston.
Gooch, Billy Allen, (Int.),
Univ. of Texas Med. Br., Galveston.
Goolsbee, Robert L., (Int.),
Univ. of Texas Med. Br., Galveston.
Grant, David Alan, (Int.),
113 Trout, Galveston.
Green, Robert Paul,
823 6th Ave., N., Texas City.
Gregory, Raymond L.,
Care Med. College, Galveston.
Guy, Robert S., (Int.),
John Sealy Hosp., Galveston.
Haggard, Mary Ellen,
John Sealy Hosp., Galveston.
Hander, William W.,
Univ. of Texas Med. Br., Galveston.
Hansen, Arild E., 4319 Caduceus, Galveston.
Harris, Titus H., John Sealy Hosp., Galveston.
Harrison, A. Wilson,
Univ. of Texas Med. Br., Galveston.
Hartel, Charles J., (Int.),
315 Goodhue Bldg., Beaumont.
Headlee, Robert E., 1125 6th St., Texas City.
Hejtmancik, Milton R.,
816 Strand St., Galveston.
Henry, Billy W., (Int.),
112 N. Boulevard, Galveston.
Herrmann, George R.,
Univ. of Texas Med. Br., Galveston.

Hoffmann, George T., (Int.),
John Sealy Hosp., Galveston.
Hooks, Charles A., 816 Strand, Galveston.
Hooks, Murray D., (Int.),
1123 62nd St., Galveston.
Hopps, Howard C.,
Univ. of Texas Med. Br., Galveston.
Jackson, Ira J.,
Univ. of Texas Med. Br., Galveston.
Jameson, Grace K., 112 North Blvd., Galveston.
Jarrell, Norman D.,
822 Sixth St., N., Texas City.
Jarvis, Garth L.,
Univ. of Texas Med. Br., Galveston.
Jinkins, A. J., 2402 Sealy, Galveston.
Jinkins, Julius L., 22nd & Sealy, Galveston.
Jinkins, Julius L., Jr., 906 22nd St., Galveston.
Jinkins, Wiley J., Jr., 828 Ave. E, Galveston.
Johnson, James E., Jr., (Int.),
201-D Nolan, Galveston.
Johnson, Jesse B., 2201 Ave. D, Galveston.
Johnson, Jesse B., Jr.,
816 U. S. Natl. Bk. Bldg., Galveston.
Johnson, John E., Jr.,
Univ. of Texas Med. Br., Galveston.
Jones, Edgar F., 2402 Sealy, Galveston.
Joyner, Roy E., 114 21st Ave., N., Texas City.
Kamin, Peter B., 22nd & I Ave., Galveston.
Kealey, Edward T., 709 6th St., N., Texas City.
Kirksey, Oscar T., Jr., 915 Strand, Galveston.
Klein, Elihu I.,
U. S. Natl. Bk. Bldg., Galveston.
Kolb, Weldon G., 421 S. Oak, LaMarque.
Lancaster, Howard E., Jr., (Int.),
John Sealy Hosp., Galveston.
Laughlin, John Milton,
Univ. of Texas Med. Br., Galveston.
Leake, Wilson W., (Int.),
John Sealy Hosp., Galveston.
Lefeber, Edward J.,
611 U. S. Natl. Bk. Bldg., Galveston.
Levin, William C.,
Univ. of Texas Med. Br., Galveston.
Lewis, Stephen R., John Sealy Hosp., Galveston.
Lionti, Joseph N., 823 6th Ave., N., Texas City.
Lockhart, Leroy D., (Int.),
Univ. of Texas Med. Br., Galveston.
Lyons, Robert E., (Mil.), Galveston.
Maddox, Henry E., III, (Int.),
103 Whiting, Galveston.
Magliolo, Albert M., Dickinson.
Magliolo, Amedeo A., Dickinson.
Magliolo, Andrew J., Dickinson.
Magliolo, Joseph C., Dickinson.
Manske, Gerhard R., (Dead).
Mantooth, Gloria E. R., (Int.), Dickinson.
Mares, Charles F.,
801 U. S. Natl. Bk. Bldg., Galveston.
Marr, William L.,
611 U. S. Natl. Bk. Bldg., Galveston.
Matlage, William T.,
219 6th St., N., Texas City.
McCash, Wray B., (Int.),
Univ. of Texas Med. Branch, Galveston.
McDanald, Eugene C., Jr.,
112 N. Boulevard, Galveston.
McGivney, John, 2202 Ave. L, Galveston.
McGolrick, Jack B., Box 873, Galveston.
McKenna, Lou Tomlinson,
1102 Ave. E, Galveston.
McLarty, E. Sinks, 1906 21st St., Galveston.
McLarty, E. Sinks, Jr.,
131 San Fernando Dr., Galveston.
McReynolds, George S.,
615 N. Boulevard, Galveston.
Middleton, John W., 900 Strand, Galveston.
Moore, Robert M.,
John Sealy Hosp., Galveston.
Mosely, Mack J., Jr.,
2509½ Market St., Galveston.
Mullins, J. Fred, 927 Strand, Galveston.
Nasta, Armando, (Mil.),
Marine Corp Base, Camp Pendleton, Cal.
Nau, Carl A., Jr., (Int.),
928 Strand, Galveston.
Newman, Pierce P., Jr., (Int.),
St. Patrick's Hosp., Lake Charles, La.
Oates, James R., (Int.),
2335 Swift, Houston.
O'Bryant, Julian W.,
528 22nd St., Texas City.
Otto, John L., 112 N. Boulevard, Galveston.
Paley, Hyman W.,
John Sealy Hosp., Galveston.
Pappas, Patrick H., (Int.),
John Sealy Hosp., Galveston.
Parker, James P., 2430 Cedar Dr., LaMarque.
Parrish, Beuford F., 1123 23rd St., Galveston.
Patterson, Marcel,
Univ. of Texas Med. Branch, Galveston.
Pennal, Hugh A., (Int.),
124 Baracuda, Galveston.
Poth, Edgar J., 1021 Bayou Shore, Galveston.
Potter, William B., 1801 Broadway, Galveston.
Powell, L. Charles,
John Sealy Hosp., Galveston.
Prujansky, Nathan, 2201 Ave. D, Galveston.
Quinn, Clarence F., 822 6th St., N., Texas City.
Randall, Edward, Jr.,
205 Natl. Hotel Bldg., Galveston.
Reeves, John P., 820 10th Ave., N., Texas City.
Rigdon, Raymond H.,
Univ. of Texas Med. Branch, Galveston.
Ritchie, Earl B., 22nd & Sealy, Galveston.
Robertson, Gaynelle,
2317 Broadway, Galveston.
Robinson, H. Reid, (Hon.),
810 U. S. Natl. Bk. Bldg., Galveston.
Rosenblad, Joanna M.,
830 10th Ave., N., Texas City.
Rosenblad, Lawrence E., Box 171, Texas City.
Ross, Marcus L., 2402 Sealy, Galveston.
Rowe, Caroline W.,
John Sealy Hosp., Galveston.
Rowe, Edward B., John Sealy Hosp., Galveston.
Ruskin, Arthur,
Univ. of Texas Med. Branch, Galveston.
Sarles, Harry E., (Int.),
John Sealy Hosp., Galveston.
Sarwold, Albert N., 1501 Broadway, Galveston.
Schmidt, Henry A.,
830 10th Ave., N., Texas City.
Schneider, John P.,
1709 San Antonio, Austin.
Schneider, Martin,
Univ. of Texas Med. Branch, Galveston.
Schofield, Norman D.,
John Sealy Hosp., Galveston.
Schwab, Edward H.,
611 U. S. Natl. Bk. Bldg., Galveston.
Sharp, William B.,
Univ. of Texas Med. Branch, Galveston.
Singleton, A. O., Jr.,
Univ. of Texas Med. Branch, Galveston.
Slocum, Harvey C., (Mil.),
Walter Reed Hosp., Washington 12, D. C.
Smith, Dan R., 2402 Sealy, Galveston.
Smith, Eugene L., (Inac.),
Box 526, Hitchcock.
Smith, Otto O., 219 Sixth St., W., Texas City.
Snodgrass, Samuel R., 800 Ave. B, Galveston.
Soloff, Philip N., (Int.),
Univ. of Texas Med. Branch, Galveston.
Spiller, William F., 22nd & Sealy, Galveston.
Spires, Albert B., Jr., (Mil.), San Antonio.
Stanton, Elbert M., 501½ 25th St., Galveston.
Stembridge, Vernie A., (Mil.),
Armed Forces Inst., Washington 25, D. C.
Stephen, Weldon W., 22nd & Sealy, Galveston.
Stephens, Charles A., (Int.),
8 Lyncrest Dr., Galveston.
Stiernberg, Douglas D.,
702 Ninth St., N., Texas City.
Stiernberg, R. Cam,
126 20th Ave., N., Texas City.
Stirling, E. Hopkins,
28 South Shore Dr., Galveston.
Stoeckle, Harry G. E., Jr.,
Univ. of Texas Med. Branch, Galveston.
Stone, Charles T., Jr.,
U. S. Natl. Bk. Bldg., Galveston.
Stone, Charles T., 2201 Ave. D, Galveston.
Stubbs, James B., 1501 Broadway, Galveston.
Sullivan, Robert E., Jr., 421 S. Oak, LaMarque.
Sykes, Clarence S., 2201 Ave. D, Galveston.
Thiel, John M.,
Univ. of Texas Med. Branch, Galveston.
Thoma, George W., Jr.,
St. Mary's Infirmary, Galveston.
Thompson, Edward R.,
707 U. S. Natl. Bk. Bldg., Galveston.
Thompson, S. Gwaine,
Carle Hosp. Clinic, Urbana, Ill.
Thornton, William R., (Int.),
5 Manor Way, Galveston.
Tips, Robert L., (Int.),
Univ. of Texas Med. Branch, Galveston.
Towler, Martin L., John Sealy Hosp., Galveston.
Townsend, Frank M., (Mil.), Galveston.
Tree, Herschel G.,
831 5th Ave., N., Texas City.
Trotter, Billy Bob, (Mil.),
805 Fairchild, Lackland Field.
Tucker, William J., (Mil.),
Fairfield AFB, Spokane, Wash.
Twidwell, Leonard,
715 10th Ave., N., Texas City.
Verrett, Richard R.,
66 3rd Ave. Villas, Texas City.
Wagnon, William E., Jr., (Int.),
Hermann Hosp., Houston.
Weatherby, Marvine, (Int.),
5112 Ave. S, Galveston.
Weinert, Herman, Jr.,
710 U. S. Natl. Bk. Bldg., Galveston.
Wellman, Garland O.,
6th St. at 9th Ave., Texas City.
White, Edward, Jr., (Int.),
103 Pompano, Galveston.
Williams, G. Douglas,
P. O. Box 487, LaMarque.
Williams, Warren S.,
Univ. of Texas Med. Branch, Galveston.
Williamson, Paul S., Box 788, Dickinson.
Wilson, Charles J., 3801 Ave. N, Galveston.
Wilson, McClure,
2704 Houston Dr., S., LaMarque.
Wilson, William A., Hotel Galvez, Galveston.
Wolma, Fred J., Jr.,
120 Barracuda Ave., Galveston.
Wright, James C., Jr.,
6713 Fairway Dr., Galveston.

LAVACA

Boyle, James W., (Inac.),
5015 Highland Ct., Austin.
Liberty, Herbert G., 413 S. Main, Hallettsville.
Marek, Emil H., Yoakum.
Renger, Harvey, Hallettsville.
Spikes, George A.,
720 Eleventh St., Douglas, Ariz.
Wagner, Frank M., (Dead).
Wagner, Robert J, Shiner Clinic, Shiner.
Williams, Robert W., Shiner.
Yates, William H., (Sec'y.), Hallettsville.

VICTORIA-CALHOUN-GOLIAD

Allen, Richard C., Jr.,
1702 N. Laurent, Victoria.
Avant, W. Harold, (Mil.),
1508 E. Mimosa St., Victoria.
Bade, Craig P., 2006 N. Navarro, Victoria.
Bauer, James E., 403 W. Laurel Ave., Victoria.
Bickford, Colon U., 2007 N. Laurent, Victoria.
Bolton, Billy F., 2701 N. Azalea, Victoria.
Borchers, Charles L.,
2006 N. Navarro, Victoria.
Bridges, Doye R., 2701 N. Azalea, Victoria.
Cogswell, Jack W., 2701 N. Azalea, Victoria.
Cohen, Kenneth, (Mil.), Foster AFB, Victoria.
Coleman, James L., Jr.,
2517 Laurent, Victoria.
Coleman, Winton L., (Pres.),
2203 Retama, Victoria.
Constant, George A., 306 N. Moody, Victoria.
Crabtree, Jerry W., 401 E. Murray St., Victoria.
Dodson, Partie May,
1801 N. Laurent St., Victoria.
Duckworth, Frederick L.,
3005 Mayfair Dr., Victoria.
Ehlert, Edward A., Jr., 121½ S. Main, Victoria.
Ferguson, R. H., (Hon.), (Dead).
Gilliam, Rochell B.,
1801 N. Laurent, Victoria.
Glover, George E., Jr.,
2008 N. Navarro, Victoria.
Griffin, John W., Box 7, Port Lavaca.
Hilderbrand, Harold E., Goliad.
Hopkins, Joseph V.,
420 Natl. Bk. Bldg., Victoria.
Horine, Maurice S., 117 Ash St., Port Lavaca.
Jones, Lloyd C., 2701 N. Azalea, Victoria.
Kleiman, Harold (Sec'y.),
2707 N. Laurent, Victoria.
Lancaster, York, 623 N. Virginia, Port Lavaca.
Lander, Roy S., 1501-E N. De Leon, Victoria.
Lester, Stanley W., Port Lavaca.
Logsdon, Francis M.,
P. O. Box 551, Port Lavaca.
Martin, Thomas Lee,
2701 N. Azalea, Victoria.
McCollum, C. J., 402 E. Guadalupe, Victoria.
McGlothlen, George E., Box 3347, Victoria.
Messer, Clarence R., Seadrift.
Mooney, Ern C., 2008 N. Navarro, Victoria.
Norton, John A., (Mil.), Foster AFB, Victoria.
Obert, Paul M.,
Citizens Mem. Hosp., Victoria.
Pratt, George H., 1406 N. Laurent St., Victoria.
Reed, Roy G.,
Victoria Co. Health Dept., Victoria.
Reiner, Robert N., (Mil.),
Foster AFB, Victoria.
Sale, Walter W., Natl. Bk. Bldg., Victoria.
Seger, Eva Y., 108 E. Loma Vista, Victoria.
Seger, Forrest M., 2008 N. Navarro, Victoria.
Shields, Allen H., 106 N. Liberty, Victoria.
Smith, D. Heaton,
1501-A N. De Leon, Victoria.
Smith, William G.,
Guadalupe St., Port Lavaca.
Southern, Jack, (Mil.),
211 Lariat Lane, Victoria.
Sterne, Thomas L., 2701 N. Azalea, Victoria.
Stevenson, Rufus A., Jr.,
2601 N. Azalea St., Victoria.
Story, Joseph R., 1501-D N. De Leon, Victoria.
Tomb, Andrew S., P. O. Box 602, Victoria.
Walker, John H., 1506 N. Laurent, Victoria.
Ward, Rawley W.,
401 W. Stayton Ave., Victoria.
White, Ben Henson, 1702 N. Laurent, Victoria.

Wilhite, Hilton R., 2601 N. Azalea, Victoria.
Williams, Charles H., 4321 Bettis Dr., Houston.
Wright, Arthur G., Jr., Point Comfort.

WHARTON-JACKSON-MATAGORDA-FORT BEND

Amman, Franz E., (Sec'y.),
806 3rd, Rosenberg.
Arbuckle, Bertrand D.,
201 E. Jackson, El Campo.
Bader, Joseph N., Box 816, Edna.
Barbour, J. Lane, 2417 Ave. G, Bay City.
Bauknight, James M., Ganado.
Black, Vernon A., 105 Hawes St., Wharton.
Blasingame, F. J. L., (Hon.),
1350 N. Astor St., Chicago, Ill.
Boswell, Samuel R., P. O. Box 72, Rosenberg.
Brewer, Paul L., Box 308, Bay City.
Cannon, Joseph N., Jr., Box 1467, Bay City.
Caraway, Robert B., 105 Hawes St., Wharton.
Cowart, James E., Box 1467, Bay City.
Cutbirth, Seale T., 105 Hawes St., Wharton.
Doss, George W., Box 846, Edna.
Dye, Fulton E., 2230 Ave. F, Bay City.
Fretz, Howard Z., 105 Hawes St., Wharton.
Furbeck, G. Nelson, 2213 Ave. G, Bay City.
Halamicek, John A., Box 167, El Campo.
Halamicek, John F., Box 167, El Campo.
Horton, Granville E.,
210 N. Houston, Wharton.
Jackson, Robert H., Jr., 2230 Ave. F, Bay City.
Johnson, Leonard B., El Campo.
Johnson, R. G., Newgulf.
Kaplan, Hyman, Jr., 1100 Ave. G, Bay City.
Kemp, Clarence S., Med. Center, Navasota.
Kleinman, Isaac, 3203 Ave. H, Rosenberg.
Knolle, Ben E., 1300 First St., Rosenberg.
Kolle, Fred W., 105 Hawes St., Wharton.
Kuykendall, Harold D.,
Med. & Surg. Clinic, Sugar Land.
Leslie, Robert E.,
606 W. Jackson St., El Campo.
Little, Raymond D., 105 Hawes St., Wharton.
Mangum, Hugh J., M. B. M. S. Bldg., Bay City.
Matthes, Homer C., 1100 Ave. G, Bay City.
McGee, Borden M., P. O. Box 868, Rosenberg.
McKinney, William C., Box 696, Edna.
McMasters, Stanley R., Box 910, El Campo.
Mortland, S. Richard, Ganado.
Nichols, C. V., 202 4th St., Richmond.
Northington, Harold M.,
210 N. Houston, Wharton.
Outlar, L. Bolton, 210 N. Houston, Wharton.
Presley, Walter D., El Campo.
Reeves, Hiram V., (Hon.), El Campo.
Sanford, E. B., Box 1488, Palacios.
Sawyers, James R.,
Bader Sawyers Clinic, Edna.
Schuhmann, J. Daniel, East Bernard.
Scott, Will E., P. O. Box 72, Rosenberg.
Shoultz, Charles A., Box 993, Bay City.
Simons, Bryan E., Bay City.
Simons, James W., Newgulf.
Stengl, Lorraine I., Box 429, El Campo.
Stepan, John D., 206 W. Monsarette, El Campo.
Thiltgen, Winston S., El Campo.
Thompson, Stanley E., (Pres.),
202 4th St., Richmond.
Voelker, Chris A., P. O. Box 548, Wharton.
Voulgaris, Dennis M., 105 Hawes St., Wharton.
Wilcox, Leroy A., Palacios.
Woodson, Clinton E., 105 Hawes St., Wharton.
Yelderman, Gus C., Box 326, Rosenberg.
Yelderman, Joe C., Needville.
Yelderman, Robert L., Box 1003, Rosenberg.

NINTH DISTRICT

Dr. Herbert H. Duke, Baytown, Councilor

AUSTIN-WALLER

Bolton, M. Graham, (Sec'y.),
12th & Wilkens, Hempstead.
Gordon, Virgil, Sealy.
Hackfield, Alfred J., Industry.
Harle, James B., Neely Bldg., Bellville.
Hopkins, Jesse J., Box 845, Brookshire.
Justiss, Jesse E., Jr., Box 427, Wallis.
Miles, Dallas D., (Pres.), Waller.
Neely, Jubal, A., Bellville.
Neely, Robert A., 22 N. Bell, Bellville.
Neely, Winston B., Neely Bldg., Bellville.
Roensch, Herbert E., Bellville.
Smith, Frank T., Jr., 317 Fowlkes St., Sealy.
Walker, Sidney C., Hempstead.

GRIMES

Coleman, Solon D., Navasota.
Conkling, William Scott, (Sec'y.),
500 E. Washington, Navasota.
Hansen, C. Marius, Box 227, Navasota.
Ketchum, Everard T., (Pres.) Navasota.
Parker, Marshall E., (Hon.), Anderson.
Stewart, Homer L., (Dead).
Thompson, Hardy E., 127 Dolphin, Galveston.

HARRIS

Abbott, Jack P., 6516 Bertner Blvd., Houston.
Able, Luke W., (Sec'y.),
905 Hermann Prof. Bldg., Houston.
Abolafia, Max, 2502 Canal St., Houston.
Adam, George F., 4510 Caroline St., Houston.
Adamo, Dominick C.,
411 W. 20th St., Houston.
Adams, Granville Q.,
Hermann Prof. Bldg., Houston.
Ainsworth, Joseph T., 6515 Lawndale, Houston.
Alexander, Charles S.,
Hermann Prof. Bldg., Houston.
Alexander, George G.,
1029 E. Thomas, Pasadena.
Alexander, Herbert L.,
4404 San Jacinto, Houston.
Alexander, James K.,
1200 M. D. Anderson Blvd., Houston.
Alford, Bobby R., (Int.),
3910 Law St., Houston.
Alford, Jack A., (Mil.), Houston.
Alger, Leon J., 624 Tatar St., Pasadena.
Allen, Herbert C., Jr.,
6516 Bertner Dr., Houston.
Allen, Leonardo, (Inac.),
Med. Arts Bldg., Houston.
Alvord, Ellsworth C., Jr.,
1200 M. D. Anderson Blvd., Houston.
Ameen, Ray C., 8849 Long Point Rd., Houston.
Ames, Frederick D., 2708 Weslayan, Houston.
Anchell, Melvin,
9129 E. Houston Rd., Houston.
Anderson, A. Burton,
Hermann Prof. Bldg., Houston.
Anderson, Thomas A., Jr.,
2708 Weslayan, Houston.
Andres, David, 906 E. Southmore St., Pasadena.
Andrew, John G., (Int.),
904 E. Southmore, Pasadena.
Andrew, Leora P., 8060 Moline, Houston.
Andrews, Tom A., Jr.,
Hermann Prof. Bldg., Houston.
Andronis, Aristos C.,
1105 Med. Towers, Houston.
Antony, O. Owen, 2921 Luell St., Houston.
Applebe, Edward W., (Hon.),
1806 Holman, Houston.
Arango, George A., 4115 Fannin St., Houston.
Archer, Francis C.,
721 E. Texas Ave., Baytown.
Armbrust, Charles A., Jr.,
4109 Montrose Blvd., Houston.
Armstrong, John T.,
Hermann Prof. Bldg., Houston.
Armstrong, Willie O., Box 2197, Houston.
Arnold, Hiram P.,
Hermann Prof. Bldg., Houston.
Arnold, Hugh F.,
1402 Hermann Prof. Bldg., Houston.
Arnold, Jasper H., 1611 Med. Towers, Houston.
Arnold, William T.,
Hermann Prof. Bldg., Houston.
Ashkenazy, Moses, 910 Med. Towers, Houston.
Ashmore, Charles M., 5503 Crawford, Houston.
Aston, William, 8802 Curry Rd., Houston.
Atkins, Richard D., Jr.,
3229 Wisconsin, Baytown.
Atlas, Joe, 5408 Palms Center, Houston.
Atlas, Leon T., 624 Tatar, Pasadena.
Avery, Eldridge F.,
906 E. Southmore, Pasadena.
Aves, Frederick H.,
4520 Rossmoyne Blvd., Houston.
Axelrod, Alexander,
1009 Med. Arts Bldg., Houston.
Axelrod, William, 1109 Med. Towers, Houston.
Babcock, Darrow S., 2921 Luell St., Houston.
Baird, Raleigh W., Jr.,
3701 Montrose Blvd., Houston.
Baird, Val C., 382 Humble Bldg., Houston.
Baker, Lowell B., 1805 Crawford, Houston.
Ballantyne, A. J.,
6723 Bertner Blvd., Houston.
Bancroft, Chas. E., 4828 Caroline, Houston.
Banfield, Michael D., 3004 Holman, Houston.
Barfield, Frank T., Jr., (Int.),
Hermann Hosp., Houston.
Barkley, Howard T.,
4414 Montrose Blvd., Houston.
Barkley, Howard T., Jr., (Int.),
Presbyterian Hosp., Philadelphia, Pa.
Barnes, J. Peyton, 617 Med. Towers, Houston.
Barnhart, Joseph M.,
1817 Dryden Rd., Houston.
Barrett, John H., 1304 Walker Ave., Houston.
Barton, Harry L.,
2002 Holcombe Blvd., Houston.
Bash, Vincent C., Jr.,
8849 Long Point Rd., Houston.
Batmanis, Elizabeth,
4010 Montrose Blvd., Houston.
Bayer, Bernard H., 104 E. 20th St., Houston.
Bayles, Spencer,
1200 M. D. Anderson Blvd., Houston.
Beakley, Bess,
8916 Spring Branch Dr., Houston.
Beard, Earl F., 6655 Travis, Houston.
Behr, Thomas S., 5656 Westheimer, Houston.
Behrens, Charles A.,
5644 Lawndale St., Houston.
Bell, Exter F., Jr., (Int.),
1510 Hermann Prof. Bldg., Houston.
Bell, Justin E., 2255 W. Holcombe, Houston.
Belleggie, Philip A.,
5019 Westheimer, Houston.
Bennett, Hugh D.,
2002 Holcombe Blvd., Houston.
Bennett, William H., (Hon.), Humble.
Benson, William F.,
906 E. Southmore, Pasadena.
Bergsagel, Daniel E.,
6723 Bertner Dr., Houston.
Bernard, Lynn A.,
Hermann Prof. Bldg., Houston.
Berumen, Joe F., 618 Tatar St., Pasadena.
Berumen, Thelma C.,
317 Park Towers Bldg., Houston.
Best, Paul W., 807 Med. Arts Bldg., Houston.
Bettis, Moody C., 706 Med. Towers, Houston.
Betts, William A., Jr., 4205 Leeland, Houston.
Bevil, Jack N., 606 Med Arts Bldg., Houston.
Beyer, Alvin, Jr., 1119 Lovett Blvd., Houston.
Bickel, Laura C., 30 Oakdale, Houston.
Biles, Ervin W., 6621 Fannin St., Houston.
Billups, J. T., Hermann Prof. Bldg., Houston.
Bing, Arlys W., Box 94, Fairbanks.
Bing, Lyndon W., Katy.
Birdsell, John E.,
8411 E. Houston Rd., Houston.
Blackburn, Bill R.,
Hermann Prof. Bldg., Houston.
Blackburn, Edward A., Jr.,
1304 Walker Ave., Houston.
Blair, Lyman C.,
1212 Rothwell, Houston.
Blair, Robert K., 2418 Travis, Houston.
Blattner, Russell J.,
Baylor College of Med., Houston.
Blish, M. Eleanor,
4705 Montrose Blvd., Houston.
Bloom, Fred A., 10 Chelsea Place, Houston.
Bloom, Manuel G., 912 Med Towers, Houston.
Bloxsom, Allan P., 4402 Travis St., Houston.
Blum, Morton A., 6410 Fannin St., Houston.
Blundell, J. Reese,
302 Med. Arts Bldg., Houston.
Boice, Edward H., (Int.),
1213 Potomac Dr., Houston.
Bonham, Russell F., Box 6237, Houston.
Bonin, Wilfred P., 1601 W. Alabama, Houston.
Boone, Carroll L., 704 Heron Lane, Pasadena.
Boone, James B.,
Southmore Hosp.-Clinic, Pasadena.
Boren, James S.,
1016 Med. Arts Bldg., Houston.
Bourdon, Lynn L., 414 W. 20th St., Houston.
Bowen, Shirley S., 1215 Walker Ave., Houston.
Bowie, Albert Ely, 3117 Dowling St., Houston.
Bowie, Carl W., (Int.),
7613 Albacore, Bellaire.
Bowles, John D., 618 Prairie, Houston.
Boyd, Adam N., 2918 Caroline St., Houston.
Boyd, Charles D., 6717 Sherwood, Houston.
Boylston, Bedford F., (Dead).
Braastad, Frederick W.,
Hermann Prof. Bldg., Houston.
Braden, Albert H., Jr.,
No. 2 Chelsea Place, Houston.
Bradford, F. Keith,
435 Hermann Prof. Bldg., Houston.
Brady, Randle J., 3317 Binz, Houston.
Bragg, William J., Jr.,
3004 Little York Rd., Houston.
Brandau, George H.,
619 Med. Arts Bldg., Houston.
Brandes, E. B.,
1700 E. Holcombe Blvd., Houston.
Brandon, Sylvan,
703 Med. Arts Bldg., Houston.
Brannon, Jack G., 2715 Fannin St., Houston.
Bratteng, Elizabeth H.,
1729 Sunset Blvd., Houston.
Brauer, Raymond O., 6615 Travis, Houston.
Braun, Howard E., 5900 Lyons Ave., Houston.
Breckenridge, Carlyle G.,
2014 Crawford, Houston.
Brelsford, Harold J.,
4062 Tartan Lane, Houston.
Brener, Lazard S.,
1200 Bissonnet, Houston.
Brener, Zidella S., 2325 Bluebonnet, Houston.
Bressler, J. L., 1215 Walker Ave., Houston.

Brewer, Raymond L.,
6800 Long Point Rd., Houston.
Brewer, Thomas W.,
Hermann Prof. Bldg., Houston.
Bridges, William H., 504 W. Defee, Baytown.
Brockman, H. Leroy, Jr.,
6723 Bertner Blvd., Houston.
Brodsky, Alexander E.,
505 Med. Towers, Houston.
Brown, Clarence A.,
6701 Carvel Lane, Houston.
Brown, Hugh N., (Int.),
5511 New Haven Ct., Austin.
Brown, Jack Ross, 1702 Ave. K, Galena Park.
Brown, James A., 5101 Almeda, Houston.
Brown, John H., 1319 S. Richey, Pasadena.
Brown, John R.,
3004 Little York Rd., Houston.
Brown, R. Alex, 7401 Harrisburg, Houston.
Brown, William K.,
Hermann Prof. Bldg., Houston.
Brown, Wilson G., Hermann Hosp., Houston.
Broyles, George D., Jr.,
Hermann Prof. Bldg., Houston.
Bruce, George D., 721 E. Texas Ave., Baytown.
Bruhl, Charles E., (Hon.),
1706 N. Boulevard, Houston.
Bruhl, Charles K.,
Hermann Prof. Bldg., Houston.
Brumby, William M., (Hon.),
811 Capital Ave., Houston.
Bryan, John J., 6026 Milart St., Houston.
Bryan, W. G., 2701 Fannin St., Houston.
Bukowski, John,
532 N. Esperson Bldg., Houston.
Bukowski, Lucian M., 1814 Crawford, Houston.
Buldain, Martha, 4510 Caroline St., Houston.
Bullock, Elza V., 906 E. Southmore, Pasadena.
Bunting, John J.,
4705 Montrose Blvd., Houston.
Burch, Neil R.,
1200 M. D. Anderson Blvd., Houston.
Burdeaux, Billie D., Jr.,
815 Med. Arts Bldg., Houston.
Burdick, Jesse G., Ethyl Corp., Pasadena.
Burg, Abner D., 806 Med. Towers, Houston.
Burge, Curtis H.,
Hermann Prof. Bldg., Houston.
Burke, Thomas W., Esperson Bldg., Houston.
Burkhalter, Archie H.,
906 E. Southmore, Pasadena.
Burnett, Mathew D., Jr.,
Hermann Prof. Bldg., Houston.
Burr, Harry B., 503 Med. Arts Bldg., Houston.
Burrows, John B.,
Hermann Prof. Bldg., Houston.
Butera, J. M., 1814 Crawford St., Houston.
Butler, Donald B., 1509 Med. Towers, Houston.
Cady, Lee D., V. A. Hosp., Houston.
Cain, Donald N.,
904 E. Southmore, Pasadena.
Calaway, F. Otis, 3820 Austin, Houston.
Calhoun, C. Alsworth,
824 Hermann Prof. Bldg., Houston.
Cameron, Bruce M., 5220 Travis St., Houston.
Campbell, G. Maury,
Hermann Prof. Bldg., Houston.
Candis, Dean J.
4520 Rossmoyne Blvd., Houston.
Cantrell, Wm. Allen,
706 Med. Towers, Houston.
Caplovitz, Coleman D.,
1120 Med. Towers, Houston.
Caplovitz, Harry 1120 Med. Towers, Houston.
Cappleman, William P.,
203 Bayshore Dr., Baytown.
Caram, Pedro, 1708 Med. Towers, Houston.
Carlton, Lawrence E.,
4119 Montrose Blvd., Houston.
Carrigan, E. W., Jr.,
106 W. Jackson, Pasadena.
Carrington, Dewitte C.,
4010 Montrose Blvd., Houston.
Carrithers, Clem M., 2921 Luell St., Houston.
Carroll, James A., (Int.),
5106 Creekbend, Bellaire.
Carroll, Roland B.,
1204 Med. Arts Bldg., Houston.
Carter, Edgar H., 5102 N. Main St., Houston.
Carter, James D., 1027 Park Towers, Houston.
Carter, Margaret A., 602 Lamar, Houston.
Carter, R. Edward, Jr.,
1701 S. Shepherd Dr., Houston.
Cato, Dorothy A.,
1400 Hermann Drive, Houston.
Cavazos, Ninfa, 307 Chartres, Houston.
Cecala, Philip J.,
2319 S. Shepherd Dr., Houston.
Chalmers, Presley H., 2310 Gramercy, Houston.
Chamberlin, James Allen,
1501 Hermann Prof. Bldg., Houston.
Chandler, Edwin A., 6611 Travis, Houston.
Chao, Dora Hsi-chih,
Methodist Hosp., Houston.
Chapin, Elisha H., Rice Hotel, Houston.
Chapman, Don W.,
Hermann Prof. Bldg., Houston.
Chapman, Frank C., (Int.),
5203 Jessamine St., Bellaire.
Chernosky, Marvin E.,
Hermann Prof. Bldg., Houston.
Chun, Merven,
7444 Harrisburg Blvd., Houston.
Chunn, Edward K.
914 Medical Towers, Houston.
Clark, R. Lee, Jr.,
6723 Bertner Blvd., Houston.
Clark, William A.,
3407 Montrose Blvd., Houston.
Clarke, Edward T.,
2404 Rice Blvd., Houston.
Clarke, Herndon H.,
2015 Dryden Rd., Houston.
Clarke, Jared E.,
713 Med. Arts Bldg., Houston.
Clarke, Thomas P., 514 Med Towers, Houston.
Clarkson, Ira S., 3205 Fannin, Houston.
Clayton, George W.,
1200 M. D. Anderson Blvd., Houston.
Cline, Deane T.,
4520 Rossmoyne St., Houston.
Cloud, Thomas M., 613 Med. Towers, Houston.
Cochran, Chester G.,
6655 Travis, Houston.
Cockrell, J. Aubrey, 201 N. 6th, Bellaire.
Cody, Claude C., Jr., (Emer.),
1715 S. Boulevard, Houston.
Cody, Claude C., III, 1304 Walker, Houston.
Cody, James, R.,
3006 M. A. S. Apt. 6, Houston.
Cody, Melville L., 4115 Fannin St., Houston.
Coe, Richard O., Jr.,
7444 Harrisburg Blvd., Houston.
Cogburn, Charles C., 617 Tatar St., Pasadena.
Cohan, Stuart K.,
6417 Richmond Rd., Houston.
Cohen, Irvin M.,
Hermann Prof. Bldg., Houston.
Cohen, Raymond, 1700 E. Holcombe, Houston.
Cole, W. Frank,
2255 W. Holcombe Blvd., Houston.
Coleman, Ruth, 1516 Pierce St., Houston.
Collette, Allan,
1006 Med. Arts Bldg., Houston.
Collier, James L.,
4705 Montrose Blvd., Houston.
Collins, Lois Cowan,
M. D. Anderson Hosp., Houston.
Collins, Ray G.,
718 Med. Arts Bldg., Houston.
Collins, Vincent P.,
1200 M. D. Anderson Blvd., Houston.
Colpitts, R. Vernon,
703 The Med. Towers, Houston.
Compere, Thomas H.,
2631 Fenwood Rd., Houston.
Connor, Edwin E., 618 S. Tatar St., Pasadena.
Connor, W. Harris,
1220 Med. Arts Bldg., Houston.
Conte, Raphael J., 3517 Louisiana, Houston.
Cooley, Denton A.,
Baylor Med. College, Houston.
Cooper, Jack C. 2204 Baldwin St., Houston.
Cope, R. Louis,
713 Med. Arts Bldg., Houston.
Corbett, Louis B.,
3507 Crawford, Houston.
Cotlar, Nathan, 711 Med. Towers, Houston.
Coulter, William W., Sr.,
1215 Walker Ave., Houston.
Cowart, Edmund M.,
10 Chelsea Place, Houston.
Cowart, Marolyn M.,
6302 Bellaire Blvd., Houston.
Cox, Dewitt W., Jr.,
11706 Fidelia Courts, Houston.
Cox, James F., Jr.,
2701 Berry Rd., Houston.
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Cox, Joseph H., 618 Tatar, Pasadena.
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Kilgore, Morris W.,
1718 Med. Towers, Houston.
Kilgore, Newton A.,
4119 Montrose Blvd., Houston.
Kilpatrick, Hamilton W.,
1307 Monroe, Baytown.
Kincaid, Harvey L.,
5400 La Branch St., Houston.
King, Joe W., 1803 Calumet St., Houston.
Kinross-Wright, V. J.,
1200 M. D. Anderson Blvd., Houston
Kirkham, Sam H., 2807 Little York, Houston.
Kirkland, Arthur A.,
2701 Berry Road, Houston.
Kirkpatrick, Robert H.,
5150 Jackwood, Houston.
Kirkpatrick, Wm. E., 2811 Plumb St., Houston.
Kirschner, Rudolf, (Mil.),
Luke AFB, Glendale, Ariz.

Kitchen, Benjamin F., Jr.,
10 Chelsea Place, Houston.
Klanke, Charles W.,
4040 Broadway Blvd., Houston.
Klein, Perry B., 709 Med. Towers, Houston.
Kneip, A. T., (Hon.), 940 Teetshorn, Houston.
Knight, Beatrice P.,
3407 Montrose Blvd., Houston.
Knight, William R., III,
Hermann Prof. Bldg., Houston.
Knittel, A. W. Schubert,
4644 Bellaire Blvd., Bellaire.
Knolle, Guy E., 308 Med. Arts Bldg., Houston.
Knox, John M.,
1200 M. D. Anderson Blvd., Houston.
Kolodny, George R.,
1217 Med. Towers, Houston.
Kolter, Wm. Henry, Jr., (Int.),
Hermann Hospital, Houston.
Kraft, Irvin A., Baylor Med. School, Houston.
Kuebler, Luke W.,
1403 Med. Arts Bldg., Houston.
LaGrone, Columbus L., (Int.),
M. D. Anderson Hosp., Houston.
Lambert, Y. Alan, Jr.,
1614 Holland St., Houston.
Lancaster, Frank H., 4407 Rossmoyne, Houston.
Lane, George H., 1803 Calumet St., Houston.
Langford, C. H., (Hon.), Bandera.
Lapat, William, (Hon.),
2715 Arbuckle, Houston.
Latimer, Mark H., 2015 West Gray, Houston.
Latson, Joseph R.,
519 Medical Towers, Houston.
Lattimore, Joseph S.,
1004 Hermann Prof. Bldg., Houston.
Lauden, Alfred E.,
1405 Hermann Prof. Bldg., Houston.
Laurentz, Fred K., Houston City Hall, Houston.
Laurie, Ben Erle, 12748 Bertha Lane, Houston.
Lavender, Claude W., (Int.),
3710 Glenhaven St., Houston.
Law, Samuel W., (Int.),
2002 Holcombe Blvd., Houston.
Lawrence, Buell A.,
4205 Leeland Ave., Houston.
Lea, Walker A., Jr., (Int.),
Univ. Hosp., Ann Arbor, Mich.
Leach, Charles L., 358 M. & M. Bldg., Houston.
Leach, Cherry Fern M.,
3822 Swarthmore, Houston.
Leachman, Robert D., (Int.),
5147 Enyart St., Houston.
Leader, Abel J., 1813 Med. Towers, Houston.
Leary, William V., 6655 Travis, Houston.
Leaton, Robert E.,
4414 Montrose Blvd., Houston.
Leavens, Milam E.,
1006 Hermann Prof. Bldg., Houston.
Ledbetter, Abbe A.,
1603 Med. Arts Bldg., Houston.
Ledbetter, Paul V.,
1603 Med. Arts Bldg., Houston.
Lee, William L., Jr., (Mil.),
123 Montpeliar, San Antonio.
Legall, Fitzherbert H.,
222 West Dallas, Houston.
Leggett, Milbourne K.,
5000 Montrose Blvd., Houston.
Leidler, Franz, 602 Lamar Ave., Houston.
Leifeste, Homer F.,
Hermann Prof. Bldg., Houston.
Leigh, Richard E., Jr.,
1613 Med. Towers, Houston.
Leiser, Alfred E., 6655 Travis St., Houston.
Lemak, Leslie L., 1004 Med. Towers, Houston.
Lensky, Paul, 105 Med. Towers, Houston.
Leonard, Robert B., 1107 Halpern St., Houston.
Leonard, Russell J.,
309 Hermann Prof. Bldg., Houston.
Leong, Richard W.,
2002 Holcombe Blvd., Houston.
Lepere, Donald M.,
801 Milwaukee St., Houston.
Lerner, Ben L., 3817 Fannin St., Houston.
Levin, Louis, 7521 Humble Road, Houston.
Levy, George, 8561 Long Point Rd., Houston.
Levy, Moise D., 3618 Yoakum Blvd., Houston.
Levy, Moise D., Jr.,
3618 Yoakum Blvd., Houston.
Levy, Samuel A., 605 Med. Towers, Houston.
Lewis, Arthur N.,
Hermann Prof. Bldg., Houston.
Lewis, Everett B.,
Hermann Prof. Bldg., Houston.
Lewis, L. Roy, 410 West 20th St., Houston.
Leyva, Angel, 1510 Quitman St., Houston.
Lhamon, William T.,
1200 M. D. Anderson Blvd., Houston.
Lieppman, Jack E.,
414 Med. Arts Bldg., Houston.
Liggett, Charles Lee, 1015 Polly St., Baytown.
Ligon, Joseph G., (Hon.),
2214 Dorrington Ave., Houston.
Liles, Ralph, 1818 Caroline, Houston.
Lindsey, Bert G., Jr., 5200 Spruce St., Bellaire.
Lipscomb, Harry S., (Int.),
2038 Milford, Houston.
Liston, David E.,
Saratoga Spa, Saratoga Springs, N. Y.
Littell, Milton, 6521 Harrisburg, Houston.
Little, Harry M., 304 McIlhenny St., Houston.
Livesay, William R.,
4109 Montrose Blvd., Houston.
Logue, Lyle J., 1304 Walker Ave., Houston.
Lomas, Robert D., 1731 Sunset Blvd., Houston.
Lorenzen, Evelyn J.,
3911 Montrose Blvd., Houston.
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Memorial Prof. Bldg., Houston.
Lowe, Thomas E.,
3803 Harrisburg Blvd., Houston.
Lucas, J. Beeman, 410 West 20th St., Houston.
Lucci, Joseph A., Jr.,
703 Med. Towers, Houston.
Lummis, Frederick R.,
Hermann Prof. Bldg., Houston.
Lundgren, Lawrence E.,
4510 Caroline St., Houston.
Lunin, Arthur B., 4003 Bellaire Blvd., Houston.
Lyons, Robert D., 4205 Leeland Ave., Houston.
MacComb, William S.,
6723 Bertner Blvd., Houston.
MacIntyre, Robert S.,
Hermann Prof. Bldg., Houston.
Madison, John C., 2801 Blodgett, Houston.
Madsen, Alva C.,
7444 Harrisburg Blvd., Houston.
Magee, Mary Lucille,
1811 Crawford St., Houston.
Maginot, Robert W.,
411 West 20th St., Houston.
Malewitz, Edward C.,
3618 Yoakum Blvd., Houston.
Marcuse, Peter M., St. Josephs Hosp., Houston.
Maresh, Rudolph E.,
4520 Rossmoyne St., Houston.
Margraves, Ross D.,
Hermann Prof. Bldg., Houston.
Markewich, Jake, 1305 Blodgett, Houston.
Marshall, Reagan M., 3207 Fannin, Houston.
Marshall, William E., Box 3150, Baytown.
Martin, Clarence R.,
1426 Med. Arts Bldg., Houston.
Martin, John E., 616 Med. Arts Bldg., Houston.
Martin, Richard G.,
M. D. Anderson Hosp., Houston.
Mathews, William A., 624 S. Tatar, Pasadena.
Mathis, Kenneth G., (Mil.),
2312 Stratford Cts., Fort Worth.
Mathis, Robert L.,
3403 Montrose Blvd., Houston.
Maxwell, Jay C., 104 Medical Towers, Houston.
Mayes, Lee P., 618 Tatar St., Pasadena.
Mayfield, Jack H.,
Hermann Prof. Bldg., Houston.
Mazow, Jack B., 605 Med. Towers, Houston.
McAmis Robert J., 1010 Federal Rd., Houston.
McCallum, Marion J.,
2701 Berry Rd., Houston.
McCartney, Gene W., 201 N. 6th St., Bellaire.
McCasland, Clifford, 125 S Main, Highlands.
McClanahan, Henry L., (Int.),
4039 Riley, Houston.
McCleery, James M.,
1004 Seymour St., Pasadena.
McClure, Robert A.,
4426 Tonawanda St., Houston.
McConn, Robert G.,
4520 Rossmoyne Blvd., Houston.
McConnell, Jesse M.,
2407 North Main, Houston.
McConnell, Seth A., (Hon.),
1016 Ave. M½, Galveston.
McCulley, J. D., 2334 Tangley Rd., Houston.
McDonald, James F, Jr.,
2920 Kirby Drive, Houston.
McDonald, Newton F.,
915 Med. Arts Bldg., Houston.
McElhenney, Thos. R., (Int.),
Tex. Childrens Hosp., Houston.
McElveen, William C.,
8762 Long Point Rd., Houston.
McGehee, Frank O., 5220 Travis, Houston.
McGovern, John P.,
3509 Montrose Blvd., Houston.
McGraw, John P.,
3503 Montrose Blvd., Houston.
McGuire, John O., 2701 Berry Road, Houston.
McGuire, Thomas H.,
601 Med. Arts Bldg., Houston.
McGurl, Frank J.,
1100 Holcombe Blvd., Houston.
McIndoe, Frank W.,
1509 Med. Arts Bldg., Houston.
McKay, Haden E., Jr., Box 625, Humble.
McKeever, Duncan C.,
2716 Portsmouth, Houston.
McKinley, Thomas R.,
1108 Houston Blvd., South Houston.
McKinney, Mary Ann,
5000 Montrose Blvd., Houston.
McMeans, Robert H.,
Medical Arts Bldg., Houston.
McMullen, Faber F., Jr., (Int.),
Hermann Hosp., Houston.
McMurrey, Allen L., 1204 Eagle St., Houston.
McMurrey, James D.,
1200 M. D. Anderson Blvd., Houston.
McMurrey, Samuel P.,
1000 East James St., Baytown.
McNamara, Dan G., 6621 Fannin St., Houston.
McNatt, James K., 8518 Jensen Dr., Houston.
McNeely, John F., Box 872, Pasadena.
McNeill, A. S., 5301 Fannin St., Houston.
McNiel, James R., (Int.),
Hermann Hosp., Houston.
McPeak, Edgar M.,
4109 Montrose Blvd., Houston.
McReynolds, Isaac S.,
815 Med. Arts Bldg., Houston.
McReynolds, John W., Jr.,
4804½ Yale St., Houston.
McReynolds, Robert J.,
3822 Broadway, Houston.
McRoberts, William A.,
Hermann Prof. Bldg., Houston.
McSpadden, Floyd F.,
414 West 20th St., Houston.
Megarity, Andrew L., Jr., (Int.),
5251 Falvey St., Houston.
Meisler, Irwin M., 5217 Holmes Rd., Houston.
Melton, Walter T.,
503 Med. Arts Bldg., Houston.
Meltzer, Leonard, 1413 Med. Towers, Houston.
Mendell, David, 1706 Med. Towers, Houston.
Mendell, Henry E.,
4003 Bellaire Blvd., Houston.
Mendell, Jack L., 4003 Bellaire Blvd., Houston.
Merriman, George J., Jr.,
P. O. Box 14464, Houston.
Messer, Jesse N., Medical Arts Bldg., Houston.
Meyer, Henry S., 1203 Cleburne, Houston.
Meynier, Maurice J., Jr.,
1601 Calhoun, Houston.
Miller, A. Pidd, 6135 Cavanaugh St., Houston.
Miller, Arthur L., (Inac.),
1245 Yale St., Houston.
Miller, G. Maxwell, La Porte.
Miller, George V., Hermann Hospital, Houston.
Miller, Gus, 104 East 20th St., Houston.
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6134 Belmark St., Houston.
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4702 Yoakum Blvd., Houston.
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2259 W. Holcombe Blvd., Houston.
Minor, Walter J., 3024 Holman St., Houston.
Mintz, A. Aaron,
1318 Telephone Rd., Houston.
Mitchell, A. Lane, 3820 Fannin St., Houston.
Mitchell, Donald D., Box 3428, Bellaire.
Mitchner, James M., 412 W. 32nd St., Houston.
Mock, Presley J., P. O. Box 638, La Porte.
Moers, Arthur E., 401 Melrose Bldg., Houston
Moers, Robert O.,
1325 Med. Arts Bldg., Houston
Mohle, Flavius D.,
3902 Montrose Blvd., Houston.
Moise, Leonard D.,
509 Indiana, South Houston.
Molloy, James P., Jr., 1102 Elgin St., Houston.
Montague, Laura J. 6613-A Travis, Houston.
Montgomery, Charles F.,
301 Med. Arts Bldg., Houston.
Moody, Irving W., 2418 Travis St., Houston.
Moody, Joe Marshall, 602 Lamar St., Houston.
Moore, Conard D., (Int.),
93 Crabtree Dr., Levittown, Pa.
Moore, Duncan L.,
Herman Prof. Bldg., Houston.
Moore, George L.,
709 Medical Towers, Houston.
Moore, Jack, Hermann Prof. Bldg., Houston.
Moore, Robert A.,
1106 Med. Towers, Houston.
Moore, Thomas O., Jr.,
Hermann Prof. Bldg., Houston.
Moore, William D., (Int.),
9726 Bassoon, Houston.
Moorhead, William H.,
5000 Montrose Blvd., Houston.
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1234 Sheffield Blvd., Houston.

Morgan, James R., (Int.),
6514 Stroud Drive, Houston.
Morgan, Ray M., Jr.,
Hermann Prof. Bldg., Houston.
Morris, Al Kelly, 1001 Polly, Baytown.
Morris, George C., Jr.,
1200 M. D. Anderson Blvd., Houston.
Morrison, J. Winston,
4528 Griggs Rd., Houston.
Morrow, Edwin J.,
1603 Med. Arts Bldg., Houston.
Moten, William M.,
300 Hermann Prof. Bldg., Houston.
Moursund, Myles P.,
1019 Hermann Prof. Bldg., Houston.
Moursund, W. H., (Emer.),
5625 Jackson, Houston.
Mumford, David M.,
1729 Sunset Blvd., Houston.
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518 Med. Arts Bldg., Houston.
Nail, Ben M., Jr., 1002 Med. Towers, Houston.
Nance, John O., 325 West 20th St., Houston.
Nathan, Mayer M., Jeff Davis Hosp., Houston.
Neidhardt, Henrich W,
M. D. Anderson Hosp., Houston.
Neil, Carleton M., 2920 Kirby Drive, Houston.
Nelson, Norman C., (Mil.),
Charity Hosp., New Orleans, La.
Nelson, Robert S.,
6723 Bertner Blvd., Houston.
Nesselrode, John E., 3130 Wisconsin, Baytown.
Newman, Alex,
Jefferson Davis Hosp., Houston.
Newton, Berne L., Methodist Hospital, Houston.
Nichols, Claude R., Jr., (Int.),
1714 Hillcrest Dr., Durham, N. C.
Nichols, John Wm.,
208 North Main, Galena Park.
Nickey, Laurance N., (Int.),
1601 S. Shepherd Dr., Houston.
Nicosia, Ralph V., 805 Westheimer, Houston.
Norris, John E., Hermann Prof. Bldg., Houston.
Norris, Ronald F.,
1610 Med. Prof. Bldg., Houston.
Norton, Joseph G., 4205 Leeland, Houston.
O'Brien, Richard F., 1713 Huge Oaks, Houston.
O'Brien, Robert B., 1713 Huge Oaks, Houston.
O'Donnell, William W.,
3200 Caroline, Houston.
O'Heeron, Michael K.,
1804 Med. Towers, Houston.
Ohlhausen, S. G., 2827 Renshaw, Houston.
Oldham, Dudley Y., 5503 Crawford, Houston.
Olin, Walter G., Jr., Hermann Hosp, Houston.
Oliver, J. Stanley, 7444 Harrisburg, Houston.
Oliver, John T., 7444 Harrisburg, Houston.
Oliver, William D., Box 61, Galena Park.
Olsen, Roy W., 5124 Richmond Rd., Bellaire.
Olson, Stanley W.,
1200 M. D. Anderson Blvd., Houston.
O'Neal, Kermit C., 3747 Seminole, Houston.
Orman, McDonald,
Medical Arts Bldg., Houston.
Orr, Guy H, 5043 Bellfort, Bellaire.
Ory, Edwin M., 810 Med. Towers, Houston.
Osborne, Clarence F., Box 769, Pasadena.
Overstreet, John W.,
Hermann Prof. Bldg., Houston.
Overton, Robert C., Jr.,
Hermann Prof. Bldg., Houston.
Owen, William R.,
Hermann Prof. Bldg., Houston
Owens, John B., 613 Harold Ave., Houston.
Owers, Albert, 6655 Travis St., Houston.
Owsley, William C., Jr.,
Hermann Hospital, Houston.
Page, J. Herbert, (Inac.),
5517 Crawford St., Houston.
Painter, Joseph T.,
1603 Med. Arts Bldg., Houston.
Palm, William M., 2014 Crawford, Houston.
Panzarella, Carlo J., P. O. Box 766, Humble.
Park, David R., 4010 Montrose Blvd., Houston.
Parker, George E., 4115 Caroline, Houston.
Parnell, Claude J., Jr., (Int.),
Hermann Hospital, Houston.
Parr, Luther H., 825 Med. Arts Bldg., Houston.
Parrish, Frank F.,
Hermann Prof. Bldg., Houston.
Paton, Donald M., 6611 Travis, Houston.
Patrick, Ralph C.,
907 Med. Arts Bldg., Houston.
Patten, Thelma A.,
222 West Dallas St., Houston.
Patterson, Robert T., 1503 Tuam, Houston.
Patterson, William B.,
1126 S. Tatar St., Pasadena.
Pawelek, I. L., 222 Med. Arts Bldg., Houston.
Pawelek, Louis G.,
222 Med. Arts Bldg., Houston.
Peck, T. T., Jr., 721 E. Texas Ave., Baytown.
Peddie, George H.,
804 Hermann Prof., Houston.
Peek, John S., 10409 Palestine St., Houston.
Pemberton, Charles W.,
222 West Dallas St., Houston.
Perdue, George W., No. 2 Chelsea Pl., Houston.
Perry, Eugene B., 222 West Dallas, Houston.
Perry, John L., Jr., 4705 Montrose, Houston.
Peters, I. D., Hermann Prof. Bldg., Houston.
Petersen, Henry A.,
820 Med. Arts Bldg., Houston.
Peterson, Carl A., 4710 Lillian, Houston.
Petri, Karin A., 4119 Montrose Blvd., Houston.
Petway, Aileen, 3302 Cloverdale St., Houston.
Petway, Max E., 8802 Curry Road, Houston.
Pfeffer, John F., 1516 Pierce, Houston.
Pfeiffer, Eva Marie,
5404 Palms Center, Houston.
Phelps, Kenton R.,
Hermann Prof. Bldg., Houston.
Phillips, Elliott S., 1803 Crawford, Houston.
Phillips, John M., Jr.,
4525 Creekbend Dr., Houston.
Phillips, John R., Medical Arts Bldg., Houston.
Phillips, Leon, 1902 Blodgett, Houston.
Phipps, John, 8262 Park Pl. Blvd., Houston.
Pipkin, Robert W., Box 3663, Baytown.
Pittman, James E.,
Hermann Prof. Bldg., Houston.
Pokorny, Alex D.,
2002 Holcombe Blvd., Houston.
Pollard, Claude, Jr.,
Hermann Prof. Bldg., Houston.
Pope, James W.,
Hermann Prof., Bldg., Houston.
Potts, Charles R., 1304 Walker Ave., Houston.
Powell, Elizabeth B.,
3002 San Felipe Rd., Houston.
Powell, Norborne B.,
830 Hermann Prof., Houston.
Poyner, Herbert F.,
1014 Med. Arts Bldg., Houston.
Pranke, Don W.,
411 Hermann Prof. Bldg., Houston.
Pratt, Helen L., 302 S. 7th St., Bellaire.
Pratt, Willard M., 918 Lovett, Houston.
Price, William P., 1009 W Main St., Houston.
Prince, Homer E., 808 Caroline, Houston.
Pritchett, I. E., (Hon.), Angleton.
Pronin, Arthur 5307 Cavalcade, Houston.
Pugsley, Cornelius, Jr.,
Hermann Prof. Bldg., Houston.
Pulliam, L. T., Medical Arts Bldg., Houston.
Purnell, Guy W., 411 West 20th St., Houston.
Purnell, Howard G.,
9013 Long Point Rd., Houston.
Qualtrough, Walter F.,
4716 Montrose Blvd., Houston.
Queen, Dan M., 6720 Bertner Blvd., Houston.
Radcliffe, Glen J., 10805 Willowisp, Bellaire.
Radding, Robert S., 6615 Travis, Houston.
Rader, John F.,
7444 Harrisburg Blvd., Houston.
Ramsay, William E.,
4705 Montrose Blvd., Houston.
Rape, Marvin G.,
915 Med. Arts Bldg., Houston.
Raymer, Warren J., 808 Caroline, Houston.
Red, William S., Jr., 2918 Caroline, Houston.
Redmon, Agile H., Jr.,
Hermann Prof. Bldg., Houston.
Rednick, Meyer S., 104 East 20th St., Houston.
Reece, Charles D.,
Hermann Prof. Bldg., Houston.
Renfrow, W. Frank,
1302 Med. Arts Bldg., Houston.
Ribelles, Jacqueline L.,
985 Bunker Hill Rd., Houston.
Ribelles, Jose A.,
985 Bunker Hill Rd., Houston.
Richardson, Joe B.,
1017 Med. Arts Bldg., Houston.
Richeson, Rae A.,
Hermann Prof. Bldg., Houston.
Ried, Hubert L., 2229 Dorrington, Houston.
Riley, Gorman L.,
4515 Mangum Road, Houston.
Rivers, Franklin M., 4520 Rossmoyne, Houston.
Robbins, E. Freeman,
2024 Richmond Ave., Houston.
Robbins, Galen P.,
1603 Med. Arts Bldg., Houston.
Robbins, Horace T.,
2024 Richmond Ave., Houston.
Robbins, Leonard R.,
3618 Yoakum Blvd., Houston.
Roberson, Edward, Jr.,
1010 Federal Rd., Houston.
Robertson, Joseph W.,
Hermann Prof. Bldg., Houston.
Robertson, Robt. C. L.,
Hermann Prof. Bldg., Houston.
Robey, Grace Lucile,
802 Hermann Prof. Bldg., Houston.
Robey, Louis R., 4104 Lyons Ave., Houston.
Robinett, James B., Jr., 3434 Norris, Houston.
Robins, Bill, Continental Bk. Bldg., Houston.
Robinson, Fred W., 5101 Caroline, Houston.
Robinson, Hampton C.,
Hermann Prof. Bldg., Houston.
Robinson, W. Tryon, 6410 Fannin, Houston.
Robison, J. M., 1304 Walker Ave., Houston.
Rodgers, Lawrence R.,
5000 Montrose Blvd., Houston.
Roemhild, Franklin N.,
1100 E. Holcombe, Houston.
Roett, Catherine J. E.,
3262 Holman St., Houston.
Rogers, Stanley F., 1009 Med. Towers, Houston.
Rohrer, Geo. E.,
1110 Med. Arts Bldg, Houston.
Rollins, Wiley J., 1217 Calhoun, Houston.
Rose, Jack M., Hermann Prof. Bldg., Houston.
Rose, Raymond G., 6723 Bertner Dr., Houston.
Rosenberg, Harvey S., 6621 Fannin, Houston.
Rosenthal, Morris Wm.,
8561 Long Point Rd., Houston.
Rothenberg, Lionel H., 618 Tatar St., Pasadena.
Roy, Harry L., Jr.,
9017 Long Point Rd., Houston.
Royce, Thomas L.,
Hermann Prof. Bldg., Houston.
Ruiz, John J., 7919 Park Pl. Blvd., Houston.
Ruiz, Richard S., (Int.),
4001 River Drive, Houston.
Rumph, Quah, Medical Arts Bldg., Houston.
Russell, Thomas G.,
5000 Montrose Blvd., Houston.
Russell, William O.,
6723 Bertner Blvd., Houston.
Rutledge, Felix N., 4828 Caroline, Houston.
Ryan, Andrew J., (Mil.),
3970th USAF Hosp., New York, N. Y.
Ryan, Bert M., 1048 Cruse Dr., Pasadena.
Ryan, James C., 1516 Pierce Ave., Houston.
Ryan, James E., 2103 Demilo Dr., Houston.
Sacco, Allen C., 1102 Elgin, Houston.
Salerno, Joseph P., 1717 La Branch, Houston.
Salinger, Alfons, 2212 Calumet Dr., Houston.
Salmeron, Pedro, Jr., 2409 Canal St., Houston.
Salmon, George W.,
3911 Montrose Blvd., Houston.
Salyer, Charles P., 3004 Little York, Houston.
Sammons, James H.,
111 San Jacinto St., Highlands.
Sammons, Karl T., 111 San Jacinto, Highlands.
Samuels, Melvin L.,
M. D. Anderson Hosp., Houston.
Sanders, Charles B.,
1526 Med. Arts Bldg., Houston.
Sanders, Elmer K.,
Hermann Prof. Bldg., Houston.
Sanders, Zal H., 1318 Telephone Rd., Houston.
Sanderson, Thomas A.,
2320 Southgate, Houston.
Sappington, H. O., Box 4128, Baytown.
Sargent, Bernis Lee, 5102 N. Main St., Houston.
Scardino, Peter H., (Hon.),
4018 Meadow Lake, Houston.
Schaffer, Elliot N., 1208 Wayside, Houston.
Schaffer, Helen G., 2905 La Branch, Houston.
Schaffer, Randolph L.,
102 Med. Towers, Houston.
Schaffer, Samuel S., 2905 La Branch, Houston.
Schaffner, Harold B.,
3102 San Jacinto, Houston.
Scheid, Martin E., (Int.),
Hermann Hosp., Houston.
Scher, David, 216 Med. Arts Bldg., Houston.
Scheurich, Richard E.,
105 E. Texas Ave., Baytown.
Schiflett, J. Ray, II, Box 875, Almeda.
Schmitt, John R., 4528 Griggs Road, Houston.
Schnur, Howard L., (Dead).
Schnur, Roxana R., 5127 Jackwood, Bellaire.
Schnur, Sidney, Medical Arts Bldg., Houston.
Schoenvogel, Otto F., Jr.,
Herman Prof. Bldg., Houston.
Schofield, James Roy,
1200 M. D. Anderson Blvd., Houston.
Schrum, David I., 2229 Dorrington, Houston.
Schuhmacher, L. F., Jr.,
Hermann Hospital, Houston.
Schuleman, Israel H.,
918 Med. Towers, Houston.
Schultz, Jacob F., 1304 Walker, Houston.
Schuman, Arnold J., 5202 Spruce St., Bellaire.
Schwartz, Harold R.,
1215 Med. Towers, Houston.
Schwartz, Max J., 1204 Wayside Ave., Houston.
Scott, Dan W., 1818 Crawford St., Houston.
Scott, Russell, Jr.,
1200 M. D. Anderson Blvd., Houston.
Seale, Everett R.,
1017 Med. Arts Bldg., Houston.

Searle, Noel B., (Int.),
1910 Brunson St., Houston.
Sears, Ernest S., 346 West 19th St., Houston.
Sears, Mary E.,
M. D. Anderson Hosp., Houston.
Secor, Harold E., 5202 Spruce St., Bellaire.
Selders, Raymond E.,
1601 S. Shepherd, Houston.
Selke, Oscar O., Jr.,
Hermann Hospital, Houston.
Sengelmann, W. A.,
513 Med.Arts Bldg., Houston.
Seybold, Herbert M., 5420 Caroline, Houston.
Seybold, William D.,
Hermann Prof. Bldg., Houston.
Shapiro, Edward M., 624 Tater St., Pasadena.
Sharkey, Paul C., (Int.),
1315 W. Clay St., Houston.
Sharp, William E., 721 E. Texas, Baytown.
Shaw, Edward N., 4115 Fannin St., Houston.
Shaw, Leroy B., (Int.),
Denver Gen. Hosp., Denver, Colo.
Shearer, Thomas P.,
Hermann Prof.. Bldg., Houston.
Shelton, Elvin L., Jr.,
Hermann Prof. Bldg., Houston.
Sher, Benjamin, 8906 Memorial Dr., Houston.
Sher, Malcolm F.,
515 Hermann Prof. Bldg., Houston.
Sherrill, Douglas B., 617 Tatar St., Pasadena.
Sherrill, E. Allen, Jr.,
3102 San Jacinto, Houston.
Sherrill, William M.,
3102 San Jacinto, Houston.
Shields, John C., 624 Tatar St., Pasadena.
Shindler, Thomas O.,
Hermann Prof. Bldg., Houston.
Shoemaker, Emitt H., 2920 Kirby Dr., Houston.
Shoemaker, Roger D.,
410 West 20th St., Houston.
Short, Dennis W.,
Hermann Prof. Bldg., Houston.
Shoss, Joseph, 10521 S. Post Oak, Bellaire.
Shrader, Harold E.,
906 E. Southmore St., Pasadena.
Shullenberger, C. C.,
6723 Bertner Blvd., Houston.
Shutts, Paul E., 5326 Calhoun Rd., Houston.
Siegel, Jacob, 7410 Long Point Rd., Houston.
Silverblatt, Julian,
901 Hermann Prof., Houston.
Silverman, Robert A., 1603 Lorraine, Houston.
Simkin, Samuel, 1606 Med. Towers, Houston.
Sinclair, Marga H., 703 Med. Towers, Houston.
Sinclair, Thomas A.,
414 West 20th St., Houston.
Singleton, Edward B.,
6621 Fannin St., Houston.
Singleton, Paul C. A.,
6410 Fannin St., Houston.
Skaggs, Ray H., Hermann Prof. Bldg., Houston.
Skelton, James M., 2708 Weslayan, Houston.
Skinner, Samuel J., (Int.),
228 Emerson St., Houston.
Skogland, John E., 3200 Caroline St., Houston.
Slataper, Eugene L., The Med. Towers, Houston.
Slaughter, Carlos A., Box 217, Sugarland.
Smith, Alfred E., 411 West 20th St., Houston.
Smith, Burt B., 5101 Caroline, Houston.
Smith, Clifford T., (Inac.),
3461 Piping Rock, Houston.
Smith, Edward T., 6410 Fannin St., Houston.
Smith, Harry S., 2708 Weslayan St., Houston.
Smith, J. Leslie, Jr.,
M. D. Anderson Hosp., Houston.
Smith, J. Murry, Medical Arts Bldg., Houston.
Smith, P. Woodbury,
2255 W. Holcombe, Houston.
Smolens, Nathan M., (Mil.),
402 West James St., Baytown.
Snow, William J.,
708 Med. Arts Bldg., Houston.
Snyder, Hal, 4520 Rossmoyne, Houston.
Snyder, Harvey B., 1216 Main St., Houston.
Snyder, John T., Box 708, Channelview.
Sonenthal, I. Ronald, 1200 Bissonnet, Houston.
Spankus, Willerd H., 3527 Ella Blvd., Houston.
Speck, Carlos D., Jr.,
3709 Montrose Blvd., Houston.
Speidel, Thomas H.,
1010 N. Federal Rd., Houston.
Spence, Philip S., Jr.,
1037 Esperson Bldg., Houston.
Spencer, Walter C. E.,
1316 Med. Arts Bldg., Houston.
Spencer, William A.,
1300 Kenwood Lane, Houston.
Spezia, Joseph L., 4832 Caroline, Houston.
Spiller, John B., Medical Arts Bldg., Houston.
Spiller, Rachel F., (Int.),
1308 Banks, Houston.
Spiller, William F., Jr.,
5000 Montrose Blvd., Houston.
Sponsel, Thane T.,
1002 Hermann Prof. Bldg., Houston.
Stackhouse, Howard, Jr.,
1222 Med. Arts Bldg., Houston.
Stahl, David M., 1504 Med. Towers, Houston.
Stalnaker, Paul R., (Hon.),
4715 Fannin, Houston.
Stanford, John P., Jr.,
207 Med. Arts Bldg., Houston.
Staub, John D., 2255 W. Holcombe, Houston.
Stehlin, John S., Jr.,
6723 Bertner Dr., Houston.
Stent, Paul A., 4208 Ella Blvd., Houston.
Stephens, Mollie M., 1025 S. Wafer, Pasadena.
Sterling, Russell R.,
917 Bk. of Southwest, Houston.
Sterns, Jerome E., 1114 Med. Towers, Houston.
Stevenson, Murphy D.,
Hermann Prof. Bldg., Houston.
Stool, Joseph A., 2417 Glen Haven, Houston.
Storey, Sharon S., Jr., (Int.),
6534 Wynnwood St., Houston.
Stork, Walter J., 816 Med. Towers, Houston.
Strough, John T., 4501 Fannin St., Houston.
Strashun, Mat F., 1811 Crawford St., Houston.
Strassmann, Erwin O.,
Hermann Prof. Bldg., Houston.
Straw, Kenneth, 6517 Lawndale, Houston.
Stuermer, Cassie E., 1324 Federal Rd., Houston.
Subotnik, Nathan,
6425 Richmond Rd., Houston.
Sullivan, Margaret P.,
M. D. Anderson Hosp., Houston.
Surgi, Marie L., 3709 Montrose Blvd., Houston.
Sutow, Wataru W.,
M. D. Anderson Hosp., Houston.
Synnott, James D.,
414 West 20th St., Houston.
Synnott, Thomas G.,
1917 Ashland St., Houston.
Tackaberry, A. L. W., (Hon.),
2707 Grant St., Houston.
Talley, Arthur T., Jr.,
1307 Med. Arts Bldg., Houston.
Talley, Elizabeth D.,
11757 Taylor Crest, Houston.
Talty, Matthew H., Jr.,
1809 Crawford, Houston.
Tashnek, Arthur B.,
1411 Med. Towers, Houston.
Tatar, Mervin, 617 Tatar St., Pasadena.
Tausend, Harold J., 5012 Travis St., Houston.
Tausend, Paul L., 211 S. Main St., Pasadena.
Taylor, Fred M., Baylor Med. College, Houston.
Taylor, H. Newell, No. 2 Chelsea Pl., Houston.
Taylor, Harvey Grant,
M. D. Anderson Hosp., Houston.
Taylor, Holman, Jr.,
Hermann Prof. Bldg., Houston.
Taylor, Homer A., Jr.,
1422 Med. Arts Bldg., Houston.
Telford, Jane, 2010 Banks, Houston.
Tempesta, James E., (Int.),
2002 Holcombe Blvd., Houston.
Teng, Ch'ing Tseng,
Jeff Davis Hosp., Houston.
Terrell, James Wm.,
Humble Oil & Refy., Baytown.
Thannisch, George E., (Int.),
Hermann Hosp., Houston.
Tharp, Warren B.,
2259 W. Holcombe Blvd., Houston.
Thoma, Earl W., Medical Arts Bldg., Houston.
Thomas, Albert M.,
808 Med. Arts Bldg., Houston.
Thomas, Fred P., Hermann Hospital, Houston.
Thomas, George B.,
5000 Montrose Blvd., Houston.
Thomas, John R.,
Hermann Prof. Bldg., Houston.
Thomas, Sellers J., Jr.,
Hermann Prof. Bldg., Bellaire.
Thomas, Stephen, 4040 Broadway, Houston.
Thomason, Edgar M., 2136 Yale St., Houston.
Thompson, B. D., 5655 Briar Dr., Houston.
Thompson, Raymond D., (Mil.),
8561 Long Point Rd., Houston.
Thompson, Walker,
4610 Cedar Oaks, Bellaire.
Thorn, Sylvester W., 1501 Calumet, Houston.
Thorning, W. B., Jr.,
4119 Montrose Blvd., Houston.
Tindel, Roland L.,
804 Mulberry Lane, Houston.
Tips, Eugene F., 802 Med. Towers, Houston.
Topek, Nathan H.,
1426 Med. Arts Bldg., Houston.
Torno, Curtis J., 1029 Thomas St., Pasadena.
Trible, John B.,
1625 Med. Arts Bldg., Houston.
Trunnell, Jack B.,
6723 Bertner Blvd., Houston.
Tucker, Eli J., 610 Med Arts Bldg., Houston.
Tucker, J. Norris,
526 Med. Arts Bldg., Houston.
Tucker, Sheldon M.,
104 East 20th St., Houston.
Turboff, Sidney W., 1603 Lorraine, Houston.
Turner, B. Weems,
Hermann Prof. Bldg., Houston.
Turner, C. Gary,
1402 Med. Arts Bldg., Houston.
Turner, James E., Jr., (Mil.),
826 College, Norman, Okla.
Turner, Louis E., (Int.),
Hermann Hosp., Houston.
Turner, Russell L., Jr.,
2136 Yale St., Houston.
Tusa, Theo S., Esperson Bldg., Houston.
Tusa, Theo S., Jr., 1608 Med. Towers, Houston.
Tuttle, L. L. D., Hermann Prof. Bldg., Houston.
Tyner, Furman H.,
704 Med. Arts Bldg., Houston.
Uetzmann, Immanuel F.,
1208 Houston Blvd., South Houston.
Ulert, Izaak A., 3304 Milam, Houston.
Upchurch, Kent P., 618 Tatar St., Pasadena.
Usher, Francis C.,
Hermann Prof. Bldg., Houston.
VandenBossche, L. J.,
104 East 20th St., Houston.
Van Velzer, David A.,
3415 Bellaire Blvd., Houston.
VanZant, Thomas J.,
Hermann Prof. Bldg., Houston.
Vaughan, Luther M.,
Hermann Hosp., Houston.
Veatch, Everett P., 211 S. Main, Pasadena.
Vick, J. Louise, 4115 Caroline, Houston.
Viehweg, Wayne R.,
1528 Med. Arts Bldg., Houston.
Vincent, Terry S., 2012 Crawford, Houston.
Vlahakos, Antonio B., 211 S Main., Pasadena.
Von Pohle, Kenneth C.,
404 Hermann Prof. Bldg., Houston.
Vose, James L.,
1200 E. Fifth Ave., Mitchell, S. Dak.
Wachsman, David V.,
1319 Austin St., Houston.
Wagner, E. Lionel.
4109 Montrose Blvd., Houston.
Wagner, Robert G., 2039 Dryden Rd., Houston.
Wagner, Robert H., 512 Med. Towers, Houston.
Wahlen, Henry E., 1602 Althea Dr., Houston.
Waites, Lucius, Jr., (Int.), Bay Springs, Miss.
Waldron, George W.,
722 Herman Prof. Bldg., Houston.
Walker, Jack L., 105 N. Rice Ave., Bellaire.
Walker, Joseph D.,
520 West 20th St., Houston.
Walker, Rhey, II,
4705 Montrose Blvd., Houston.
Wall, Herman A., Jr.,
106 W. Jackson St., Pasadena.
Wall, John A., Hermann Prof. Bldg., Houston.
Wallace, Grover C.,
906 E. Southmore St., Pasadena.
Wallace, Stuart A.,
1200 M. D. Anderson Blvd., Houston.
Wallis, Marshall, (Hon.), Box 111, La Feria.
Wallis, William M., 218 Main St., Houston.
Walmsley, George L.,
201 W. Pearce St., Baytown.
Walpole, Ben, 3101 Fannin St., Houston.
Walter, Paul J.,
Hermann Prof. Bldg., Houston.
Walton, Ida K., 719 E. Texas Ave., Baytown.
Walton, Worth, 214 W. Hunnicut, Baytown.
Warner, Clyde M., (Inac.),
3256 Reba St., Houston.
Warner, Lucien M.,
1521 Bonnie Brae, Houston.
Warren, Joseph F., Tomball.
Waters, Charles R., Box 505, Highlands.
Watson, James E., Jr.,
Hermann Prof. Bldg., Houston.
Watson, Thomas D., Jr.,
2071 Brentwood Dr., Houston.
Webb, Edward D.,
4804½ Yale St., Houston.
Weil, Sol B., Jr., 2246 Dryden Rd., Houston.
Weils, Benjamin T., (Mil.),
U. S. Army Disp., White Sands, N. Mex.
Welsh, Hugh C., 2715 Fannin, Houston.
West, Joseph E., Jr., 7338 McHenry, Houston.
Westbrook, Orian C.,
1207 Hermann Prof. Bldg., Houston.
Westmoreland, Jack C.,
3201 Weslayan St., Houston.
Westover, Harry M., (Hon.),
8910 Jensen Dr., Houston.
Westphal, Corinne, 219 W. Alabama, Houston.

Wexler, Alvin S.,
6303 S. Park Blvd., Houston.
Wheeler, Clarence J., Jr.,
Hermann Prof. Bldg., Houston.
White, Adair W., Jr., (Int.),
1423 Hewitt Dr., Houston.
White, Edgar C.,
6723 Bertner Blvd., Houston.
Whitehurst, James R.,
Hermann Prof. Bldg., Houston.
Whitsitt, James J.,
Mellie Esperson Bldg., Houston.
Whitson, Robert O.,
608 W. Defee Ave., Baytown.
Wible, D. Jordan, 3304 Milam, Houston.
Wiesenthal, Joseph, 200 Wayside, Houston.
Wigby, Palmer E.,
Hermann Prof. Bldg., Houston.
Wilber, Stewart A., 602 Lamar St., Houston.
Wilbourn, George R.,
904 E. Southmore, Pasadena.
Wilkerson, Bernie J., 705 Main St., Houston.
Wilkerson, Edward A.,
1320 Eagle Ave., Houston.
Wilkin, Mabel G.,
1400 Hermann Dr., Houston.
Williams, Bryan V.,
1704 Crawford St., Houston.
Williams, E. Carson.
Hermann Prof. Bldg., Houston.
Williamson, Warren J.,
2404 Rice Blvd., Houston.
Williamson, Willie A.,
4040 Broadway, Houston.
Wills, Seward H.,
Hermann Prof. Bldg., Houston.
Wilson, Arnold, 906 E. Southmore, Pasadena.
Wilson, Carl S., 1512 W. Alabama, Houston.
Wilson, Roy D., (Mil.),
137 B Doolittle Dr., Sherman.
Wimpee, James D., (Int.),
Children's Hosp., Iowa City, Iowa.
Windrow, Frank M.,
Hermann Prof. Bldg., Houston.
Windrow, Nuel C., Jr.,
2405 Tangley St., Houston.
Winograd, Eugene,
1708 Houston Blvd., South Houston.
Wise, Robert A., P. O. Box 2180, Houston.
Wise, Robert J.,
Hermann Prof. Bldg., Houston.
Withers, Ben T.,
Hermann Prof. Bldg., Houston.
Withers, Henry W.,
3102 San Jacinto, Houston.
Wolf, E. Trowbridge,
4411 Fannin St., Houston.
Wolf, Walter J., 1606 Med. Towers, Houston.
Wolfe, Russell S., 5101 Almeda, Houston.
Wolters, Carlton E.,
5503 Crawford, Houston.
Wood, Harold, 230 Med. Arts Bldg., Houston.
Wood, Harold A., (Mil.), 705 Baca, Houston.
Wootters, John H.,
Hermann Prof. Bldg., Houston.
Wortham, G. Forrest, Jr.,
2708 Weslayan St., Houston.
Wright, Ernest, 2407 N. Main St., Houston.
Wright, William K.,
Hermann Prof. Bldg., Houston.
Wyatt, Malcolm H., 114 N. Second, LaPorte.
Yaege, Arlo O., Box 728, Tomball.
Yates, Charles W.,
2611 Avenue G, Rosenberg.
Yen, Moore, U. of Texas Med. Sch., Galveston.
Yoder, Nelson J., 720 W Main St., La Porte.
Yollick, Bernard L.,
The Medical Towers, Houston.
York, Byron P., 3911 Montrose Blvd., Houston.
Young, Carl B., Continental Bk. Bldg., Houston.
Young, David B., 106 W. Jackson, Pasadena.
Young, John B.,
3837 Bellaire Blvd., Houston.
Youngblood, Jarvis C.,
3011 Ella Lee Lane, Houston.
Younkin, Charles R.,
5124 Richmond Rd., Bellaire.
Yow, Ellard M.,
Baylor U. Col. of Med., Houston.
Zanek, Otto L., 1610 Med. Towers, Houston.
Zax, Emile, 515 Hermann Prof. Bldg., Houston.
Zeis, Leander B., 2920 Kirby Dr., Houston.
Zeluff, George W.,
Hermann Prof. Bldg., Houston.
Zepeda, Rudolph F.,
4030 Roseneath, Houston.
Zimmerman, Stanley J., (Mil.),
APO 323, San Francisco, Calif.
Zionts, Martin A., 3507 Louisiana, Houston.

MONTGOMERY

Bell, Henry G., 101 E Phillips St., Conroe.
Brignac, Louis F., Jr.,
216½ W. Davis, Conroe.
Carroll, I. Emil, Conroe.
Holland, William M., Conroe.
Hurst, William R.,
Ave. G & Crooke, Conroe.
Hutchins, Melvin G., (Sec'y.),
324½ N. Main, Conroe.
Lenon, EE., Conroe.
Powell, Burrell E., Powell Clinic, Conroe.
Sadler, Deane L., Conroe.
Watson, Irving M., Jr., (Pres.), Conroe.
Wilkins, Afton N., 213 S. 1st St., Conroe.

POLK-SAN JACINTO

Alexander, Jewell C., (Dead).
Corso, John, Livingston.
Dabney, Joseph T., Jr., Livingston.
Dameron, James H., Livingston.
Gardner, Thomas L., Livingston.
Mitchell, L. Du-Wayne, (Sec'y.),
P. O. Box 51, Shepherd.
Olive, Roy A., Box 1172, Austin.

WALKER-MADISON-TRINITY

Addison, Eugene M., (Sec'y.), Huntsville.
Autrey, Stacy L., Trinity.
Barnes, Sam R., Trinity.
Black, F. Ray, 1312 Eleventh St., Huntsville.
Blalock, Raymond B., Huntsville.
Bush, Leonard E., Box 328, Huntsville.
Cole, Thomas C., 1203 Avenue J, Huntsville.
Cook, John R., Box 32, Trinity.
Goodrich, William A., Sr., Huntsville.
Hanson, Minter D., Huntsville.
Heath, Jesse B., Madisonville.
McKay, James A., Madisonville.
Reed, James E., Jr.,
603 S. Madison Madisonville.
Steeg, Galen E., (Pres.), Groveton.
Thornton, Harold H., Trinity.
Veazey, William B., 1203 Avenue J, Huntsville.
Woodward, W. Mac, Huntsville.

WASHINGTON-BURLESON

Dodd, Tilman E., 3303 Hillview Rd., Austin.
Giddings, Thomas H., 604 Stone St., Brenham.
Hasskarl, Robert A., Box 696, Brenham.
Hasskarl, Walter F., Sr., Brenham.
Hasskarl, Walter F., Jr., Brenham.
Hodde, Fred H., Box 601, Brenham.
Hodde, Herman O., Brenham.
Johnson, Joel H., 509 East Academy, Brenham.
Knolle, Roger E., 106½ E. Alamo, Brenham.
Knolle, Waldo A., Brenham.
Pazdral, George V., Somerville.
Schoenvogel, Clarence W., Brenham.
Schoenvogel, Otto F.,
Schoenvogel Clinic, Brenham.
Schoenvogel, Robert L., (Pres.),
Citizens Phar. Bldg., Brenham.
Siptak, John E., Caldwell.
Smith, Joe C., Caldwell.
Southern, Charles E., (Sec'y.), Brenham.
Steinbach, Herbert L., Brenham.
Tottenham, Edwin P.,
106 W. Vulcan St., Brenham.

TENTH DISTRICT

Dr. Stephen B. Tucker, Nacogdoches, Councilor

ANGELINA

Arnett, Robert K., 302 N. Raguet, Lufkin.
Atkinson, Basil E., Jr.,
923 Ellis Ave., Lufkin.
Barrett, John G., 1109 Ellis Ave., Lufkin.
Brashear, Doyle H., 919 Ellis Ave., Lufkin.
Clement, J. Carroll, 110 S. Raguet, Lufkin.
Clements, Peyton C., 402 South First, Lufkin.
Connell, Anna Beth, 1000 Frank Ave., Lufkin.
Denman, Byford H., 221 S. First St., Lufkin.
Denman, Linwood H., Box 354, Lufkin.
Denman, Peyton L., 302 S. Raguet, Lufkin.
Evans, Charles W., Jr., 1022 Ellis Ave., Lufkin.
Hoot, Edwin L., Box 307, Diboll.
Hyman, Bernard, Box 176, Lufkin.
Klein, James C., Box 1216, Lufkin.
Koch, John C., (Int.),
5379 Pasteur Blvd., New Orleans. La.
Martin, Juan E., 923 Ellis, Lufkin.
McVicker, Bobby H., Box 1076, Lufkin.
Medford, U. Gail, 110 S. Raguet St., Lufkin.
Mitchell, William A.,
201 Hemenway Bldg., Lufkin.
Orman, Forrest C., 1111 Ellis Ave., Lufkin.
Peebles, Felix, Jr., (Sec'y.),
419 Perry Bldg., Lufkin.
Pruitt, George Jack, Memorial Hosp., Lufkin.
Seitz, Ernest R.,
302 N. Raguet St., Lufkin.
Shepard, Groom S., (Pres.),
923 Ellis Ave., Lufkin.
Spivey, Dan, 818 Frank, Lufkin.
Stevenson, Stanley L., Box 427, Corrigan.
Taylor, Robert W., 118½ S. First, Lufkin.
Thames, William D., Jr.,
818 Frank Ave., Lufkin.
Tinkle, Lassiter T., 1608 S. First St., Lufkin.
Wade, Jack H., Box 1300, Lufkin.

HARDIN-TYLER

Barclay, Watt, Woodville.
Burton, L. Gayle, Box 788, Woodville.
Copeland, Sam P., Jr.,
735 North Fifth, Silsbee.
Gauntt, Eugenia T., Kountze.
Gilchrist, John Q., (Pres.), Woodville.
Hooks, Henry A., Kountze.
Parker, Wade M., 735 N. 5th, Silsbee.
Poshataske, Wallace J.,
510 N. Fifth St., Silsbee.
Ryan, Robert L., 821 Barkley St., Sour Lake.
Spidle, James L., Box 446, Sour Lake.
Swearingen, Robt. E., Box 608, Woodville.
Tate, John H., Kountze Clinic, Kountze.
Tate, Robert A., Kountze.
Tennison, George D., (Sec'y.),
440 Roosevelt Dr., Silsbee.

JASPER-NEWTON

Dickerson, Joe W., Jasper.
Henderson, John A., (Int.),
Hermann Hosp., Houston.
Jones, Gordon W., Pineland.
Jones, Thomas R., 139 W. Lamar, Jasper.
Love, Albert J., Newton.
Mattingly, Claude, Jr.,
162 E. Lamar St., Jasper.
McCreight, William F., (Hon.),
P. O. Box 218, Kirbyville.
McGrath, J. J., (Sec'y.), Jasper.
Moore, John T., (Pres.),
200 E. Lavielle, Kirbyville.
Richardson, A. J., Jr., Jasper.
Stockdale, Rider E.,
Hardy Hancock Hosp., Jasper.
Winslow, Grover C.,
Hemphill Clinic., Hemphill.

JEFFERSON

Adams, Barnette E. J., Jr.,
1950 Ninth Ave., Port Arthur.
Adams, Robert M., P. O. Box 878, Groves.
Adkins, Charles F., 675 Fifth St., Beaumont.
Alexander, Hugh E.,
2372 Calder Ave., Beaumont.
Allamon, Emmett L.,
456 1st Fed. Bldg., Beaumont.
Allison, F. Peel, Hotel Beaumont, Beaumont.
Almaraz, Herman,
2749 Procter St., Port Arthur.
Anderson, Roland B.,
1950 Ninth Ave., Port Arthur.
Bailey, Percy W., Jr.,
675 Fifth St., Beaumont.
Barr, H. Buford,
501 Perlstein Bldg., Beaumont.
Bebeau, Eugene R., 3495 Crestwood, Beaumont.
Beck, Edmund J., 2499 Calder, Beaumont.
Bell, Walter L.,
1408 West 6th St., Port Arthur.
Bevil, H. Grady, 301 Doctors Bldg., Beaumont.
Bevil, Harold H.,
1110 Longfellow Dr., Beaumont.
Bevil, John R., (Hon.),
2625 Laurel Ave., Beaumont.
Bevil, Lamar C., 2625 Laurel Ave., Beaumont.
Beyt, Frank J., 235 Adams Bldg., Port Arthur.
Blackwood, James Q.,
447 1st Fed. Savings Bldg., Beaumont.
Blum, Sigmund L., 573 Pearl St., Beaumont.
Bourgeois, Richard J.,
2301 Procter St., Port Arthur.
Boyle, Frank B., 2248 Procter St., Port Arthur.
Brandau, William H.,
703 Amer. Natl. Bk. Bldg., Beaumont.
Brittain, Robert D., Jr.,
2372 Calder Ave., Beaumont.
Brown, Walter D., (Hon.),
2262 North St., Beaumont.
Browne, Robert S., Adams Bldg., Port Arthur.
Brownrigg, Thos. H.,
1485 Calder Ave., Beaumont.
Bybee, Joe A., 400 Center Street, Beaumont.

Byram, Dan H., 2600 Procter St., Port Arthur.
Byrd, Houston F., (Sec'y.),
1322 Magnolia, Port Neches.
Byrd, Lee Roy, Jr., Box 701, Port Arthur.
Byrd, Peter G., 695½ Forsythe, Beaumont.
Caldwell, Pearson C.,
506 Goodhue Bldg., Beaumont.
Carabelle, R. Wm.,
4300 Lewis Dr., Port Arthur.
Carter, John H.,
460 1st Fed. Savings Bldg., Beaumont.
Carter, Louian C.,
2600 Procter St., Port Arthur.
Catalano, Russell J.,
502 Goodhue Bldg., Beaumont.
Chevis, Edward G.,
525 Ninth Ave., Port Arthur.
Chiasson, John L., (Hon.),
1118 Dearing St., Port Neches.
Chiasson, Mary P.,
261 E. Circuit Dr., Beaumont.
Chunn, B. D., 1200 Brdwy., Beaumont.
Cochran, E. Winston,
675 Fifth St., Beaumont.
Colby, Fred W. C., 2380 Hazel St., Beaumont.
Colletti, Ben M., 601 Ninth Ave., Port Arthur.
Couch, Ray E., P. O. Box 3277, Port Arthur.
Crager, Jay C., 601 Goodhue Bldg., Beaumont.
Crawford, Geo. F.,
318 Goodhue Bldg., Beaumont.
Crumpler, W. Emmett,
Adams Bldg., Port Arthur.
Cunningham, M. A.,
Jefferson Co. T. B. Hosp., Beaumont.
Curry, Dwight E.,
2600 Procter St., Port Arthur.
Darnell, B. C., 4620 Gladys St., Beaumont.
Douglas, Jake S., 935 Buford St., Beaumont.
Drawhorn, Chester W.,
917 Port Neches Ave., Port Neches.
Duplan, Don C., Jr.,
4627 Alamosa Drive, Port Arthur.
Duren, Norman,
315 Goodhue Bldg., Beaumont.
Durso, Joseph, 949 7th St., Port Arthur.
Echols, Obie L., 634 Avenue C, Port Neches.
Eisenstadt, Heinz B.,
2301 Procter St., Port Arthur.
Elster, Benjamin B.,
2301 Procter St., Port Arthur.
English, Dudley M., 550 Tenth St., Beaumont.
Erhard, Peter S., Box 294, Beaumont.
Esslinger, Josh J.,
301 Doctors Bldg., Beaumont.
Everett, Eva T., 1950 Ninth Ave., Port Arthur.
Fama, Joseph R., 550 Tenth St., Beaumont.
Faulk, M. Edmund, Jr.,
675 Fifth St., Beaumont.
Fears, T. Alvin, Goodhue Bldg., Beaumont.
Ferguson, Edward C.,
Goodhue Bldg., Beaumont.
Ferguson, Edward C., III,
Iowa State Univ., Iowa City, Iowa.
Fertitta, Julian J., 590 Center St., Beaumont.
Fertitta, Sam J., Jr., 570 Center St., Beaumont.
Fett, Bennie J., Adams Bldg., Port Arthur.
Fortney, Paul N., 550 Tenth St., Beaumont.
Fulbright, Carl W., (Inac.),
4230 Sunken Courts, Port Arthur.
Fuqua, Wm. Cruse,
612 Goodhue Bldg., Beaumont.
Furey, Ellen D., 1025 Avenue B, Beaumont.
Fuselier, Julius D., 749 16th St., Port Arthur.
Gardner, John N.,
613 Goodhue Bldg., Beaumont.
Gibson, U. G., 1000 Texas Ave., Port Arthur.
Gill, George G., 370 Tenth St., Beaumont.
Gish, James R., 317 Goodhue Bldg., Beaumont.
Glass, Cecil R., 2462 Calder Ave., Beaumont.
Glass, Walter W., Jr.,
508 Adams Bldg., Port Arthur.
Goldblum, Harvey H.,
3048 Procter St., Port Arthur.
Goodwin, Charles R., 109 12th St., Nederland.
Graber, W. J.,
610 Amer. Natl. Bk. Bldg., Beaumont.
Greenberg, Philip B.,
502 Perlstein Bldg., Beaumont.
Greene, W. Leonard, 670 7th St., Beaumont.
Hager, Dale C., 2040 Park St., Beaumont.
Haig, Martin R., 508 Adams Bldg., Port Arthur.
Hamill, James E., (Mil.),
2301 Procter St., Port Arthur.
Harlan, Herbert D.,
218-A San Jacinto Bldg., Beaumont.
Harper, J. Y., 849 Fifth St., Port Arthur.
Hart, Frank B., 713 Mariposa St., Beaumont.
Hart, John A., 3280 Fannin St., Beaumont.
Hartman, Lee E., (Int.), 525 Yount, Beaumont.
Hartman, Sam F., 545 23rd St., Beaumont.
Healey, Gordon, 525 9th Ave., Port Arthur.
Heare, Charles R., 390 Tenth St., Beaumont.
Heare, Louis C., Box 312, Port Arthur.
Hendry, Cullen H., 390 Tenth St., Beaumont.
Hennington, H. M.,
723 Washington Blvd., Beaumont.
Hill, Isaac H., 901 Fifth St., Port Arthur.
Hille, Charles D.,
531 Adams Bldg., Port Arthur.
Hines, J. Clarence, Box 746, Nederland.
Hinshaw, Arvil J.,
701 Goodhue Bldg., Beaumont.
Holman, Winston C.,
1931 Ninth Ave., Port Arthur.
Holmes, Glen L.,
Stagg Dr. & 8th St., Beaumont.
Hosen, Harris, 2649 Procter St., Port Arthur.
Hubner, Alan E., 590 Center St., Beaumont.
Hyman, Barnett M.,
1st Fed. Savings Bldg., Beaumont.
Ivers, James B.,
1105 Goodhue Bldg., Beaumont.
Jack, Laurine D.,
511 Goodhue Bldg., Beaumont.
Jacobson, Harry,
523 Perlstein Bldg., Beaumont.
Johnson, Jerry, 519 Goodhue Bldg., Beaumont.
Jones, E. Harrold, 2625 Laurel Ave., Beaumont.
Jones, Edmund D.,
2439 Laurel Ave., Beaumont.
Kalbaugh, Elmore P., Jr.,
2301 Procter St., Port Arthur.
Keith, Frank R., P. O. Box 110, Port Arthur.
Kennedy, Jeretta I., P. O. Box 43, Nome.
Kern, Paul J., 1104 Port Neches, Port Neches.
Killingsworth, W. Price,
541 9th Ave., Port Arthur.
Knight, John A., (Inac.), (Dead).
Knight, Max J., 900 9th Ave., Port Arthur.
Koshkin, Bernard D., 550 Tenth St., Beaumont.
Kuhlman, Fred Y.,
218 Adams Bldg., Port Arthur.
LaCour, Edward G., 2524 Brdwy., Beaumont.
Lancaster, Lifford R.,
303 Doctors Bldg., Beaumont.
Lanier, Ernest W., 6272 Jefferson St., Groves.
Larkins, L. Curtis, 755 College St., Beaumont.
Ledbetter, L. H., 550 10th St., Beaumont.
Lewis, James W., 2649 Procter St., Port Arthur.
Lewis, Seab J., 2620 Laurel Ave., Beaumont.
Lindsey, Eugene H.,
2372 Calder Ave., Beaumont.
Loewenstein, Joseph M.,
3048 Procter St., Port Arthur.
Lombardo, R. T., 810 19th St., Beaumont.
Lombardo, Thomas A.,
2510 Hazel St., Beaumont.
Lowry, Harvey M.,
319 Goodhue Bldg., Beaumont.
Lyons, Sam B., 801 Goodhue Bldg., Beaumont.
Makins, James, Medical Bldg., Port Arthur.
Mann, David A., (Hon.),
1025 Washington Blvd., Beaumont.
Manning, Wiley M., 2305 Neches, Beaumont.
Marroquin, Luis, 1632 7th Ave., Port Arthur.
Martin, John D., (Hon.),
1897 Rivercrest, Beaumont.
Matlock, Thos. B., Adams Bldg., Port Arthur.
Matthews, Julius B.,
535 West 13th St., Port Arthur.
McCall, John W., Jr.,
1785 Washington Blvd., Beaumont.
McNemer, Philip H.,
Perlstein Bldg. Annex, Beaumont.
McRee, Edgar C., Medical Bldg., Port Arthur.
McRee, Walter E., Jr., (Pres.),
3040 Procter St., Port Arthur.
Meeker, Cornelius S.,
3121 Procter St., Port Arthur.
Meyer, Paul R., 3121 Procter, Port Arthur.
Miller, Kenneth T.,
1115 Goodhue Bldg., Beaumont.
Mitchell, Theo C., 2449 Calder Ave., Beaumont.
Mixson, Harold J., Goodhue Bldg., Beaumont.
Montagnet, Joseph M., Jr.,
590 Center St., Beaumont.
Moore, Darwin D.,
701 Goodhue Bldg., Beaumont.
Moore, Robert E.,
1405 Nederland Ave., Nederland.
Newton, William A.,
2698 McFaddin St., Beaumont.
Norris, Thomas A., (Mil.),
Confederate Mem. Med. Center,
Shreveport, La.
Odell, Joyce W.,
506 Goodhue Bldg., Beaumont.
Orgeron, Eugene B.,
541 Ninth Ave., Port Arthur.
Orrick, Robt. Jack Jr.,
305 Doctors Bldg., Beaumont.
Orrill, R. Ray., Medical Bldg., Port Arthur.
Osborne, John A., Jr., 2525 Calder, Beaumont.
Pace, Bedford F., 555 Tenth St., Beaumont.
Painton, Clifford E.,
900 Ninth Ave., Port Arthur.
Pecora, Tony L., 610 Goodhue Bldg., Beaumont.
Pentecost, Chas. L., 3155 Stagg Dr., Beaumont.
Petit, Paul T., 2627 Laurel Ave., Beaumont.
Petry, James L., 3115 Procter, Port Arthur.
Phillippi, George M.,
2165 North St., Beaumont.
Pierson, Rogers, Box 2908, Beaumont.
Pitre, Roy P., County Office Bldg., Port Arthur.
Powell, James E.,
2691 Washington Blvd., Beaumont.
Quick, David W., Jr.,
601 Goodhue Bldg., Beaumont.
Rafes, Earl H., 675 Fifth St., Beaumont.
Raines, James M., 2002 Procter St., Port Arthur.
Reid, William L., 1195 McFaddin, Beaumont.
Reimers, Arthur F.,
Hotel Beaumont Bldg., Beaumont.
Richardson, Orville J., 4189 Main Ave., Groves.
Richman, Irving M., 3280 Fannin, Beaumont.
Robert, W. Pierre, 2630 Laurel Ave., Beaumont.
Rodick, John C., 2600 Procter St., Port Arthur.
Rollo, William C., Winnie.
Ross, Oliver H., 543 Ninth Ave., Port Arthur.
Rumelt, Allen,
3504 Highland Ave., Beaumont.
Sappington, T. B., Jr.,
102 Dryden Place, Port Arthur.
Self, Milton Myrl,
605 Goodhue Bldg., Beaumont.
Serafino, Louis C.,
452 1st Fed Savings Bldg., Beaumont.
Shaddix, Arthur C., 1186 Brdwy., Beaumont.
Sheldon, Robert B., 575 19th St., Beaumont.
Shorkey, Richard L., 370 Tenth St., Beaumont.
Shuffield, James W., Jr.,
1119 Goodhue Bldg., Beaumont.
Simpson, Rufus K.,
2372 Calder Ave., Beaumont.
Sladczyk, George, 3149 Procter, Port Arthur.
Sloan, John W.,
816 Cherry St., Ravenswood, W. Va.
Smith, Denton W., 390 Tenth St., Beaumont.
Smith, Jack L., 1555 Driskill Dr., Beaumont.
Smith, John T, 203 Doctors Bldg., Beaumont.
Smith, William A.,
211 W. Caldwood Dr., Beaumont.
Solis, G. Robert,
2749 Procter St., Port Arthur.
Sprott, Curtis B., 2390 Cartwright, Beaumont.
Sprott, E. D., Jr., 2390 Cartwright, Beaumont.
Sprott, Maxie C., 2390 Cartwright, Beaumont.
Starr, Harry, 675 Fifth St., Beaumont.
Stephenson, G. Bruce, 370 Tenth St., Beaumont.
Stevens, Robert B.,
1297 Calder Ave., Beaumont.
Stoeltje, Joe, 1170 Simmons St., Beaumont.
Suehs, Max E.,
228 San Jacinto Bldg., Beaumont.
Sutton, Fred W., Goodhue Bldg., Beaumont.
Sykes, Walter P., 3280 Fannin, Beaumont.
Tatum, William E., (Hon.),
State Road, Gatesville.
Tew, Alton H., 107 Doctors Bldg., Beaumont.
Thomas, James R., Gulf Oil Corp., Port Arthur.
Thompson, Douglas J.,
2600 Procter St., Port Arthur.
Thompson, James D.,
2600 Procter St., Port Arthur.
Todd, Charles H., 3155 Stagg Dr., Beaumont.
Toomin, Leonard A.,
3155 Stagg Drive., Beaumont.
Torbert, John W., Jr.,
1445 Calder Ave., Beaumont.
Travis, John M., Jr.,
2920 Harrison St., Beaumont.
Tritico, Joseph J., 949 7th St., Port Arthur.
Tyndall, Thomas M.,
2643 McFaddin, Beaumont.
Vaughan, Benjamin H.,
Adams Bldg., Port Arthur.
Walker, Taylor C., 2165 North St., Beaumont.
Wallace, Charles R., 860 Trinity, Beaumont.
Wallace, Loring Scott,
1119 Goodhue Bldg., Beaumont.
Wallace, Stuart M.,
1931 Ninth Ave., Port Arthur.
Wallace, William G.,
816 Goodhue Bldg., Beaumont.
Walters, Felix A.,
1133 Boston Ave., Nederland.
Watts, Fenwick L.,
2220 Procter St., Port Arthur.
Weisbach, Philip T., 560 Center St., Beaumont.
Westbrook, Bonnie B., Jr.,
723 Washington, Beaumont.
White, Ben T., II,
1950 Ninth Ave., Port Arthur.
White, Clarence M.,
618 American Natl. Bk Bldg., Beaumont.
White, J. Milton, Sr.,
3149 Procter St., Port Arthur.

White, John M., Jr.,
3149 Procter St., Port Arthur.
Wier, Stuart T.,
505 Goodhue Bldg., Beaumont.
Wilcox, Howard R.,
Hotel Dieu Hosp., Beaumont.
Williams, Chas. L., 1776 East Drive, Beaumont.
Williams, Ford G., 415 Center St., Beaumont.
Williams, Lewis M.,
3280 Fannin St., Beaumont.
Williams, Stewart M.,
714 Goodhue Bldg., Beaumont.
Williford, Herman B.,
220 San Jacinto Bldg., Beaumont.
Willoughby, Russell C., Box 535, Groves.
Woodward, John F., Jr.,
905 Goodhue Bldg., Beaumont.
Young, Isaac T., P. O. Box 147, Port Arthur.

LIBERTY-CHAMBERS

Alexander, James H., (Pres.),
P. O. Box 606, Cleveland.
Ashby, Joe M., Box 456, Anahuac.
Barnett, William L., P. O. Box 518, Cleveland.
Bellamy, Richard C., 1815 Cos Ave., Liberty.
Castle, Charles W., 717 San Jacinto, Liberty.
Clements, Richard O., 715 Main, Liberty.
Davidson, Eli, Liberty.
Delaney, Albert L., Liberty.
Fahring, George H., Anahuac.
Fahring, Thomas L., Anahuac.
Gibson, Boyce E., (Sec'y.), Hull.
Griffin, Frank S., Liberty.
Hume, Boyd Douglas, Jr.,
117 N. College, Cleveland.
Jordan, Byron Lee, (Inac.), Daisetta.
Leggett, Walter, 106 N Bonham, Cleveland.
Richter, Ernest R., Dayton.
Schulz, Donald P., 608 Travis, Liberty.
Shearer, A. R., (Hon.), Mt. Belvieu.
Wilson, Reginald, Dayton.

NACOGDOCHES

Allen, James I., Nacogdoches.
Allen, Walter B., 1301 Raguet, Nacogdoches.
Beall, J. Frank, 820 N. Mound, Nacogdoches.
Buchele, Matthew J., (Sec'y.), San Augustine.
Coussons, Charles W., (Pres.),
Box 482, Nacogdoches.
Ferguson, Sarah, 1301 Raguet, Nacogdoches.
Ferwerda, Thomas,
2311 North St., Nacogdoches.
Haley, Curtis R., Baggett Bldg., San Augustine.
McKinney, Edgar P.,
402 E. Hospital St., Nacogdoches.
McLain, Bobby M.,
724 Cynthia, Poplar Bluff, Mo.
Nelson, Albert L.,
422 E. Hospital St., Nacogdoches.
Neuville, Carroll F.,
P. O. Box 907, Nacogdoches.
Pennington, Thomas J.,
820 N. Mound, Nacogdoches.
Rogers, Eugene S., Nacogdoches.
Taylor, James G., Jr.,
1301 Raguet, Nacogdoches.
Tucker, F. Henry, Nacogdoches.
Tucker, Stephen B., Nacogdoches.

ORANGE

Allen, Rollie E., 1005 Green Ave., Orange.
Bennett, David, 409 Ninth St., Orange.
Cloud, James P., 1212 Park Ave., Orange.
Eastman, George L., 1005 Elm, Orange.
Griffin, Oscar R., Box 750, Orange.
Ingram, Robert A., P. O. Box 479, Orange.
James, Wilson E., (Sec'y.),
1005 Green St., Orange.
Kent, Earl H., Box 2032, Orange.
Key, Harry H., Box 950, Orange.
McFadden, Irma M., 609 Main St., Orange.
Minkus, Robert F., 5 Circle Q., Orange.
Peters, Leo J., Jr., 601 4th St., Orange.
Pollock, Douglas H., 411 Ninth St., Orange.
Pretz, Earnest C., 1604 N. Second St., Orange.
Seastrunk, Oliver C., 306 10th St., Orange.
Siddon, William H., P. O. Box 2054, Orange.
Smith, L. C., Box 1368, Vidor.
Stuntz, Billie W., 304 Seventh St., Orange.
Stuntz, Homer C., 304 Seventh St., Orange.
Swickard, George Y., P. O. Box 551, Orange.
Thompson, Louis O.,
121 W. 1st St., Biloxi, Miss.
Walsh, John K., 610 Park Ave., Orange.
Watson, Arthur R., 2009 Coronado Pl., Orange.
Watson, Victor D., Box 496, Bridge City.
White, Malcolm E., 203 7th St., Orange.
Williams, Howard C.,
1006 Green Ave., Orange.
Wilson, Francis W.,
307 Dwyer St., San Antonio.
Wyllie, James J., 111 Holland Bldg., Orange.

SHELBY-SAN AUGUSTINE-SABINE

Hurst, Thomas L., Center.
Oates, Laried S., 116 Cora St., Center.
Polk, Vernon T., (Sec'y.),
108 Church St., Center.
Snider, L. W., Box G, Garrison.
Warren, William H., P. O. Box 72, Center.
Warren, Wm. Spencer, Center.
Windham, John H., (Hon.), Shelbyville.
Windham, William C., P. O. Box 666, Center.

ELEVENTH DISTRICT

Dr. R. H. Bell, Palestine, Councilor

ANDERSON-HOUSTON-LEON

Bell, Robert H., (Pres.),
109 E. Angelina St., Palestine.
Brown, Adelbert B., Jr., Crockett.
Butler, Charles Wm., Jr., Box 780, Crockett.
Carter, J. Weldon, Palestine.
Cox, Robert G., (Sec'y.),
804 S. Sycamore St., Palestine.
Darsey, Edward S., Crockett.
Dean, John L., Jr., 407 East Lamar, Crockett.
Felder, Fred E., Palestine.
Funderburk, William O., (Hon.), Elkhart.
Goolsby, Carl B., Med. & Surg. Hosp., Crockett.
Griswold, Culver M.,
P. O. Box 672, Crockett.
Harrington, Oscar B.,
205 E. Neches, Palestine.
Hathcock, Alfred L., (Hon.), Palestine.
Humphries, John T., Palestine.
Hunter, Ripley H., Palestine.
Joyce, Claude D., Jr., Palestine.
Kay, Royal H., Palestine.
King, Marion A., Frankston.
Murray, Carl O., Jr., 208 S. 4th St., Crockett.
Powell, Elisha P., Centerville.
Stokes, Paul B., 210 N. 7th, Crockett.
Trice, Leroy, Palestine.
Van Wey, Archie E., Buffalo.
Wages, A. D., Palestine.
Walkup, Thomas E.,
804 S. Sycamore, Palestine.

CHEROKEE

Adams, Clyde, Box 31, Pineville, La.
Bailey, Ralph C.,
Afghanistan, Chaman, Pakistan.
Bilbro, Griff W., (Pres.),
1303 Hillcrest, Jacksonville.
Boyd, James T., 915 Hillcrest, Jacksonville,
Brigham, Floyd H., Rusk.
Chamness, Daniel E.,
400 S. Ragsdale, Jacksonville.
Cobble, Thomas H., (Sec'y.),
606 N. Main, Rusk.
Covington, Chas. M.
5909 Shoalcreek Blvd., Austin.
Crawford, Joe D., Travis Clinic, Jacksonville.
Davenport, Harbert, Jr.,
P. O. Box 1569, Jacksonville.
Fair, Harry E., Jr., Travis Clinic, Jacksonville.
Gabbert, W. E., Rusk.
Hancock, Leslie D., P. O. Box 318, Rusk.
Hill, Robert D., Travis Clinic, Jacksonville.
Hilliard, George M., Box 870, Jacksonville.
Jones, Ernest W., Box 318, Rusk.
Kreimeyer, James H., Rusk State Hosp., Rusk.
Levin, Gus, Box 318, Rusk.
Mahon, Edward L., Jr.,
Travis Clinic, Jacksonville.
Martin, Don E., Box 1470, Jacksonville.
Newburn, C. L., Box 1269, Jacksonville.
Noble, Roy C., Rusk State Hosp., Rusk.
Pryor, Victor W., 555 S. Jackson, Jacksonville.
Ralston, Leslie W.,
400 S. Ragsdale, Jacksonville.
Rives, Hugh F., 400 S. Ragsdale, Jacksonville.
Rossman, Robert E., Alto Clinic, Alto.
Rucker, J. Collier,
1117 Avalon Dr., Jacksonville.
Stacey, Royal K., Box 318, Rusk.
Stolzar, Irwin H., 315 N. Center St., Longview.
Stripling, C. H.,
555 S. Jackson St., Jacksonville.
Travis, John M., Box 870, Jacksonville.
Travis, L. L., Box 870, Jacksonville.
Travis, R. T., Box 870, Jacksonville.
Verheyden, Floyd H.,
813 John St., Jacksonville.
Woods, David R., 2314 31st St., Lubbock.

FREESTONE

Bonner, Leslie L., Box 157, Fairfield.
Cox, Jack R., Box 117, Teague.
Crossno, Joe D., Box 687, Fairfield.
Gage, Maurice, (Sec'y.), Box 278, Teague.
Jordan, Curtis R., 315 Main St., Teague.
Keller, John H., Jr., (Pres.),
Box 687, Fairfield.
Morton, Edward D., Box 308, Teague.
Sneed, William N., (Hon.), Box 103, Fairfield.

HENDERSON

Buie, Ralph R., (Int.),
4821 Piety Dr., New Orleans, La.
Cockerell, Lonnie L., Athens.
Geddie, Nolen D., Jr., Athens.
Geddie, Nolen D., Athens.
Gibson, John W., (Pres.),
300 S. Palestine, Athens.
Haynes, Clifford R., Kilman Hosp., Malakoff.
Henderson, Roy E., Athens.
Holt, Norris E., (Sec'y.),
P. O. Box, 188, Athens.
Kilman, Prather T., Malakoff.
Rosenbloom, Joseph, Trinidad.
Wilcox, Melvin R., 503 Bryson, Athens.

PANOLA

Baker, Charles D.,
111½ N. St. Mary, Carthage.
Carter, Harvey Lee, (Mil.),
708 N. Daniel St., Carthage.
Cooper, Grundy, 808 N. Daniel, Carthage.
Gerardy, Carl W., 317 Panola, Carthage.
Hargrove, Fred T.,
217 N. Pinewood Dr., Carthage.
Holland, Virgil M., 313 W. Panola, Carthage.
Johnson, Glen R., (Pres.), Box 818, Carthage.
Perlman, Samuel,
404 N. St. Mary St., Carthage.
Prince, Kenneth C., (Sec'y.),
313 W. Panola St., Carthage.
Smith, William C.,
313 W. Panola St., Carthage.

RUSK

Braswell, Marlin T.,
119 S. Marshall, Henderson.
Deason, Loyd, 300 Ragley, Henderson.
Hamilton, James M., Box 908, Overton.
Heiligman, Haskell, Overton.
Hilbun, Lynn, 119 S. Marshall, Henderson.
Jackson, P. Lamar, 116 S. Marshall, Henderson.
Kennamer, Harold E., S. Helen St., Overton.
Levin, Jules R., 108 South St., Overton.
Mann, James H., (Pres.),
116 S. Marshall, Henderson.
McShan, Chester L., (Sec'y.),
207-B North Main, Henderson.
Morris, Alfred E., 119 S. Marshall, Henderson.
Suehs, Herbert A., 817 N. Marshall, Henderson.
Suehs, Paul E., 817 N. Marshall, Henderson.
Wolfe, Alfred S., 119 S. Marshall, Henderson.

SMITH

Alexander, J. Ernest Jr., (Inac.),
214 E. Houston, Tyler.
Allen, George B., 818 Clinic Drive, Tyler.
Anderson, Carter Jr.,
712 S. Bois d'Arc, Tyler.
Bailes, Porter M., Jr.,
932 Hospital Dr., Tyler.
Baldwin, Russell E. G.,
1015 Hospital Dr., Tyler.
Bankhead, Alexander J.,
214 E. Houston, Tyler.
Baskin, T. Grady., 214 E. Houston, Tyler.
Betts, Floyd G., Jr., 1020 Clinic Drive, Tyler.
Birdwell, J. Weldon, 214 E. Houston, Tyler.
Blakemore, Henry C., 107½ E. Erwin, Tyler.
Bradford, Sidney W., 2015 S. College, Tyler.
Brelsford, H. Gates, 214 E. Houston, Tyler.
Bridges, Ben F., 214 E. Houston, Tyler.
Brown, George W., 305 W. Rusk St., Tyler.
Brown, Glynne, 432 S. Spring St., Tyler.
Brown, Irving, 815 Peoples Bk. Bldg., Tyler.
Bryant, W. Howard, P. O. Box 600, Tyler.
Bundy, David T., (Hon.),
County Court House, Tyler.
Burch, George W., 908 Hospital Drive, Tyler.
Caldwell, Elbert H., 214 E. Houston, Tyler.
Calley, Clifford R.,
1006 Clinic Drive, Tyler.
Cameron, Harold B., 214 East Houston, Tyler.
Caplinger, Robert A., 1100 S. Beckham, Tyler.
Chenoweth, Carlin Velde,
1016 Clinic Dr., Tyler.
Clawater, Earl W., Jr.,
1016 Clinic Drive., Tyler.

Clawater, Earl W., Sr., (Dead),
Daniels, Herbert B., Jr.,
911 South Beckham, Tyler.
DeCharles, Patrick M., 200 E. Houston, Tyler.
Duff, Robert L., 908 Hospital Drive, Tyler.
Edwards, Martin L.,
Edwards Clinic Hosp., Hawkins.
Ermshar, Raymond,
916-A N. Englewood, Tyler.
Etter, Roscoe, Arp.
Faust, John J., 903 S. Beckham, Tyler.
Ferrell, Oran L., Jr., Bullard.
Freiberg, Milton, 932 Hospital Dr., Tyler.
Gibson, Jesse W., (Hon.), (Dead).
Goldfeder, Jesse, Peoples Bk. Bldg., Tyler.
Goldsmith, J. Paul, 929 N. Glenwood, Tyler.
Goss, Vernon V., 908 Hospital Dr., Tyler.
Green, Frank D., (Sec'y.),
1012 E. Lake St., Tyler.
Halbrooks, Norman E., 1224 S. Azalea, Tyler.
Hart, John Garrett, 217 W. Houston. Tyler.
Hughes, Delbert E., 900 Hospital Dr., Tyler.
Hughes, Waunell M., 900 Hospital Dr., Tyler.
Jones, Joe C., 803 E. Houston, Tyler.
Jones, William T., E. Texas T. B. Hosp., Tyler.
Lamberth, Ivey E., P. O Box 3066, Tyler.
Lauck, Robert E., 1035 Clinic Dr., Tyler.
Lee, Madison J., Jr., 1100 S. Beckham, Tyler.
Marshall, Robert L., 1100 S. Beckham, Tyler.
McDonald, Conrad C., 900 Hospital Dr., Tyler.
McMillan, Bruce, Overton.
Mitchell, John H., 903 S. Beckham, Tyler.
Moore, Masters H., 612 S. Bois d'Arc, Tyler.
Mullowney, James P., 926 Hospital Dr., Tyler.
Muntz, Hascall H., 938 Hospital Dr., Tyler.
Neill, J. Lawrence, 803 E. Houston, Tyler.
Neill, Lex T., 803 E. Houston, Tyler.
Payne, Donald E., 305 West Rusk, Tyler.
Pope, Irvin Jr., 118 S. Bois d'Arc, Tyler.
Rhine, Leland R., 911 S. Beckham, Tyler.
Rice, Elbert D., 434 S. Spring, Tyler.
Rice, Robert D., 1100 S. Beckham, Tyler.
Roosth, Wiley, 1025 Hospital Dr., Tyler.
Roper, Marjorie Ferrell, Bullard.
Ross, William R., City Health Dept., Galveston.
Rowe, William E., 833 S. Beckham, Tyler.
Selman, Joseph, 1020 Clinic Drive, Tyler.
Shirley, T. Clayton, 911 S. Beckham, Tyler.
Smyth, William C., 1100 S. Beckham, Tyler.
Spence, Julius H., 3023 Jan Ave., Tyler.
Stephens, William C., 818 Clinic Drive, Tyler.
Taliaferro, Theodore J., 1106 Trezevant, Tyler.
Taylor, Phillip W., 833 S. Beckham, Tyler.
Thompson, Cone J., 810 Clinic Drive, Tyler.
Topperman, Samuel,
East Texas T. B. Hosp., Tyler.
Vaughn, Edgar H., 830 S. Beckham, Tyler.
Vaughn, James M., 830 S. Beckham, Tyler.
Warren, Frederick M., Jr.,
1012 E. Lake St., Tyler.
Whitten, Samuel J., Troup.
Wilcox, Leland G., 833 S. Beckham, Tyler.
Wiles, Jack, 1015 Hospital Dr., Tyler.
Williams, Frank E., 305½ N. Spring, Tyler.
Willingham, Chas. E.,
911 South Beckham, Tyler.
Wilson, Benjamin N., 1100 S. Beckham, Tyler.
Wimberley, Norris A., Jr.,
504 S. Spring, Tyler.
Windham, Lynn B.,
818 S. Johnson Ave., Tyler.
Woldert, Albert, (Hon.),
603 Woldert St., Tyler.
Wood, James E., 929 N. Glenwood, Tyler.
Young, Cuthbert B., (Pres.),
916 Hospital Drive, Tyler.
Zuckerman, William, Box 2003, Tyler.

WOOD

Mathis, James Ross, 408 S. Main, Winnsboro.
Merritt, Benjamin F.,
106 W. Bermuda, Quitman.
Moore, Roscoe O., (Sec'y.),
802 N. Pacific, Mineola.
Peterson, Thomas H., Mineola.
Potts, Steve E., 310 N. Newsome St., Mineola.
Reed, Theodore B., Mineola.
Robbins, Virgil E., Box 445, Quitman.
Williams, James W., Mineola.

TWELFTH DISTRICT

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Althaus, John W. A.,
McCloskey V. A. Hosp., Temple.
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Scott & White Hosp., Temple.
Arnold, William O.,
Med. Arts Bldg., Hot Springs, Ark.
Bain, George P.,
Scott & White Clinic, Temple.
Barrow, Rex A., Jr., (Int.),
Scott & White Clinic, Temple.
Bartels, Robert N. 304 S. 22nd St., Temple.
Bassel, Paul M.,
Scott & White Clinic, Temple.
Best, Edward B., (Int.),
Scott & White Clinic, Temple.
Birdsong, Karl K., (Int.),
1502 N. 2nd St., Temple.
Birdwell, Henry V., Jr., (Int.),
Scott & White Clinic, Temple.
Bradfield, Eldon O.,
Scott & White Clinic, Temple.
Brindley, George V.,
Scott & White Clinic, Temple.
Brindley, George V., Jr.,
Scott & White Clinic, Temple.
Brindley, Hanes H.,
Scott & White Clinic, Temple.
Broders, Albert C.,
Scott & White Clinic, Temple.
Broders, Albert C., Jr.,
Scott & White Clinic, Temple.
Broders, Charles W.,
Scott & White Clinic, Temple.
Brothers, Joe F., (Int.),
Scott & White Hosp., Temple.
Brown, Jesse B.,
Kings Daughters Clinic, Temple.
Bruce, William J., 916 South 45th, Temple.
Bryson, John B., Box 516, Belton.
Burk, Houston W.,
1402 E. Rancier Ave., Killeen.
Burow, F. Paul, Burow Clinic, Killeen.
Chernosky, William A.,
Kings Daughters Clinic, Temple.
Christian, John J., (Pres.),
Scott & White Clinic, Temple.
Cochran, Leroy M., V. A. Center, Temple.
Cox, Charles H., Jr., 317 N. Second, Temple.
Cramm, Carl J., Jr.,
Scott & White Clinic, Temple.
Curtis, Raleigh R.,
Scott & White Clinic, Temple.
Daly, William H., Jr.,
Burow Clinic & Hosp., Killeen.
Davis, Charles T.,
Scott & White Clinic, Temple.
DeBord, Bert A.,
1116 North 9th St., Temple.
Dysart, Donald N.,
Scott & White Clinic, Temple.
Eanes, David F. S.,
518 North 5th St., Temple.
Ellis, Ira D., (Hon.), Troy.
Fillmore, Rollin S., Jr.,
Kings Daughters Clinic, Temple.
Fowler, Joe A., 310 E. Ave. B, Killeen.
Frey, Harry,
107 Via Mentone, Newport Beach, Calif.
Gillespie, Charles H.,
Scott & White Clinic, Temple.
Gober, Olin B., Scott & White Clinic, Temple.
Greenwood, Joseph H.,
Scott & White Hosp., Temple.
Grossman, Alex., V. A. Hosp., Temple.
Haines, Richard D.,
Scott & White Hosp., Temple.
Hamilton, Dixie G., Jr.,
710 W. Rancier, Killeen.
Hammond, Fred M., Jr.,
Scott & White Clinic, Temple.
Harlan, Rudolph K.,
Kings Daughters Hosp., Temple.
Hightower, Nicholas C.,
Scott & White Clinic, Temple.
Howell, Floyd W., 317 N. 2nd St., Temple.
Hunt, Warren H., III, (Int.),
Scott & White Clinic, Temple.
Ibarra, Jesse D., Jr.,
Scott & White Clinic, Temple.
Jarvis, Walter H., Jr.,
Scott & White Clinic, Temple.
Jenkins, Jesse G., (Hon.), Rt. 1, Temple.
Keil, Ernest W., 518 North Fifth, Temple.
Kirkley, A. Rex, (Sec'y.),
P. O. Box 240, Belton.
Laurens, Henry, Jr.,
Scott & White Clinic, Temple.
Lindsey, Sherman B.,
Scott & White Clinic, Temple.
Little, Robert C.,
Scott & White Clinic, Temple.
Long, William B., 205 N. Pearl, Belton.
Lynch, Donald J.,
Scott & White Clinic, Temple.
Malooly, Donald A., (Int.),
Scott & White Hosp., Temple.
McCelvey, John S., 304 S. 22nd St., Temple.
McKenney, John F., Jr.,
Scott & White Clinic, Temple.
McMillan, Charles D.,
Scott & White Clinic, Temple.
McRoberts, Marcus L.,
710 W. Rancier Ave., Killeen.
Moore, James C.,
317 North 2nd St., Temple.
Murray, Robert A.,
Scott & White Clinic, Temple.
Nelson, Ernest J., 1406 S. 51st, Temple.
Nelson, George C., (Int.),
Scott & White Hosp., Temple.
Padgett, John W., 310 Ave B, Killeen.
Pittman, John W., Belton.
Plasek, William W., 317 N. 2nd St., Temple.
Pollok, Lewis W., (Hon.),
618 N. 13th St., Temple.
Potter, Claudia, (Hon.),
707 South 3rd St., Temple.
Powell, William N.,
Scott & White Clinic, Temple.
Rodarte, Jose G.,
Scott & White Clinic, Temple.
Schubert, Herbert A., V. A. Hospital, Temple.
Sewell, Harvey W., Belton.
Sewell, Julian G., Belton.
Shell, John R.,
2501 Drummond St., Vicksburg, Miss.
Shelton, James L.,
Scott & White Clinic, Temple.
Shibler, Samuel W.,
Kings Daughters Clinic, Temple.
Sommer, Arno W.,
Scott & White Hosp., Temple.
Speed, Terrell, Scott & White Hosp., Temple.
Spillar, Bliss R., Jr., (Mil.),
1707 N. 22nd St., Killeen.
Spillar, Edna M. H.,
1707 N. 22nd St., Killeen.
Stinson, James C., 213 W. Ave. G, Temple.
Sunbury, Thomas R.,
Scott & White Clinic, Temple.
Talley, J. Bartow, S. P. J. S. T. Bldg., Temple.
Talley, Lewis R.,
Kings Daughters, Hosp., Temple.
Thompson, John Q.
Scott & White Clinic, Temple.
Veirs, Everett R.,
Scott & White Clinic, Temple.
Wahle, George Henry, 304 S. 22nd St., Temple.
Ward, Wendell P.,
912 1st Natl. Bank, Temple.
Weinblatt, Jack S., 518 N. 5th St., Temple.
White, Raleigh R.,
Scott & White Clinic, Temple.
Whitten, Rondald J.,
1402 E. Rancier Ave., Killeen.
Williams, Bill Henry
Scott & White Clinic, Temple.
Williams, Marjorie J., V. A. Hosp., Temple.
Wilson, James D.,
Kings Daughters Clinic, Temple.
Wolf, A. Ford, Scott & White Clinic, Temple.
Woodson, W. Burbank, 103 E. Central, Temple.

BOSQUE-HAMILTON

Blankenship, W. W., Mosheim.
Cleveland, Chas. C., Hamilton.
Goodall, Van D., Clifton.
Holder, Wiseman T., (Sec'y.), Clifton.
Holt, Russell D., Meridian.
Key, William F., Jr., 719 W. 11th, Clifton.
Kooken, Robert A., Hamilton.
Long, Austin M., Valley Mills.
Witcher, Seth L., (Pres.), Clifton.

BRAZOS-ROBERTSON

Andres, Dwight W., 3501 Texas Ave., Bryan.
Benbow, Robert H., 408 W. 28th St., Bryan.
Boyd, Elvin M., 1208 Live Oak, Hearne.
Cole, Charles M., Box 747, Bryan.
Cooper, James F., 308 W. 28th St., Bryan.
Cooper, Oliver C., 408 W. 28th St., Bryan.
Cox, Joseph M., 202 E. 27th St., Bryan.
Cruse, Ray, 1208 Live Oak, Hearne
Fleming, James P., Jr., 710 Magnolia, Hearne.
Gallagher, Joseph C., Box 753, Hearne.
Geppert, Joseph W., (Sec'y.),
202 E. 27th St., Bryan.
Grant, Richard B., Jr., 308 W. 28th St., Bryan.
Guynes, Henry C., (Int.),
22 Lyncrest, Galveston.
Harris, Nena A., College Station.
Harrison, R. Henry, 109 Porter Bldg., Bryan.
Harrison, Richard H., III,
109 Porter Bldg., Bryan.
Hughes, Louis B., 710 Magnolia St., Hearne.
Lindsay, James I., 722 Garden Acres, Bryan.
Lindsey, William H., 1308 Cypress, Hearne.
Marsh, John E., Jr., 701 S. College Ave., Bryan.

Marsh, John E., Sr., College Station.
Martin, Jay W., Jr., 1803 E. 26th St., Bryan.
McGill, Albert G., 512 Varisco Bldg., Bryan.
McQuaide, Henry C., 3501 Texas, Bryan.
Melcher, Truman O., 202 East 27th, Bryan.
Perry, James S., 625 N. 30th, Waco.
Pope, Henry D., Jr., (Mil.),
FSO 3530 USAF Hosp., Bryan.
Richardson, S. C., (Hon.), Bryan.
Roman, William B., Jr., (Int.),
2138 Cambridge Dr., Irving.
Sanders, Jewell G., Bremond.
Searcy, R. M., Bryan.
Searcy, Thos. A., Hearne.
Smith, Roy L., 3501 Texas Ave., Bryan.
Taylor, William C., Jr., Calvert.
Walton, Thomas O., Box 434, College Station.
Walton, Thomas T., (Pres.), Bryan.
Wilkerson, Lonnie O., P. O. Box 1147, Bryan.

CORYELL

Barbee, Fred, P. O. Box 305, Copperas Cove.
Brown, John T., 200 N. Lutterloh, Gatesville.
Davis, J. Walker, Hamilton.
Jones, Kermit R., (Pres.), Gatesville.
Lowrey, E. Elworth,
116 N. Lutterloh, Gatesville.
Lowrey, O. Wendell, (Sec'y.), Gatesville.

ERATH-HOOD-SOMERVELL

Altaras, Leon M., Box 2, Stephenville.
Bryan, T. F., (Hon.),
121 E. Black Jack, Dublin.
Cedars, Nathan,
441 N. Belknap St., Stephenville.
Cole, Charles T., 122 N. Grafton St., Dublin.
Glynn, John H, 411 N. Belknap, Stephenville.
Hafer, Wm. Fred, (Sec'y.), Box 507, Hico.
Hedges, Homer V., (Pres.), Hico.
Herrin, Bob J., Hico Clinic, Hico.
Jordan, Carl A., 109 N. Grafton St., Dublin.
Lancaster, Gus N., (Inac.), Granbury
Pate, Joe J., 111 W. Black Jack, Dublin.
Reynolds, Avery M.,
De Leon Municipal Hospital, De Leon.
Terrell, James C., 411 N. Belknap, Stephenville.
Terrell, Vance, Box 371, Stephenville.
Terrill, Bruce S., 411 N. Belknap, Stephenville.
Weaver, Robert E.,
411 N. Belknap, Stephenville.

FALLS

Barnett, John B, Torbett Clinic, Marlin.
Bennett, Alfred C., Torbett Clinic, Marlin.
Brown, James M., Torbett Clinic, Marlin.
Buie, Neil D., Buie Clinic, Marlin.
Bussell, James S., Torbett Clinic, Marlin.
Cornwell, Charles H., Buie Clinic, Marlin.
Davison, Milton A., 407 Chambers St., Marlin.
Giles, Roy G., 417 Houghton, Marlin.
Glass, Thomas G., Buie Clinic, Marlin.
Green, John E., Sr., VA Hospital, Marlin.
Hampshire, George H., (Hon.),
215 Winters St., Marlin.
Hawkins, E. W., (Hon.),
113 Live Oak St., Marlin.
Hutchings, Edgar P., Torbett Clinic, Marlin.
McDowell, Thomas A., (Sec'y.),
229 Coleman St., Marlin.
McKinley, W. Frank, Jr.,
Torbett Clinic, Marlin.
Reese, Walter L., (Pres.),
407 Chambers St., Marlin.
Sheffield, Roy S., VA Hospital, Marlin.
Smith, Howard Lee, Torbett Clinic, Marlin.
Smith, Howard O., Torbett Clinic, Marlin.
Smith, Walter S., Torbett Clinic, Marlin.
Swepston, Happy J., Rosebud.
Swetland, Douglas R., Torbett Clinic, Marlin.
Useda, Domingo, 300 Coleman St., Marlin.

HILL

Barnes, Livingston, (Hon.), Hubbard.
Beskow, Richard N., (Pres.),
217 Craig St., Hillsboro.
Bradford, Andrew L., (Hon.), Coolidge.
Buie, James Morgan, 206 E. Elm, Hillsboro.
Campbell, Clark C., Itasca.
Cason, Dick K., 217 Craig, Hillsboro.
Garrett, Charles A., (Sec'y.),
300 Carr St., Hillsboro.
Grant, Silas W., 206 E. Elm, Hillsboro.
Guffy, Joseph L., Hillsboro.
Jenkins, Gaines H., (Hon.),
7629 Circle Dr., Lemon Grove, Calif.
Latham, John E., Jr., Whitney.
McDonald, Hendley A.,
206 N. Abbott St., Hillsboro.
Morris, Thomas M., Mount Calm.
Richey, L. E., Jr., 206 E. Elm, Hillsboro.
Sammons, Howard P., Hubbard.
Shirey, Robert W., Hillsboro.
Smith, Nellins C., 1107 Park Dr., Hillsboro.

JOHNSON

Allen, Charles G., 123 W. Main St., Itasca.
Ball, William P., Cleburne.
Barker, Gates R., 214 N. Caddo, Cleburne.
Bradford, Charles C., Box 21, Burleson.
Clark, Elmer L., 214 N. Caddo, Cleburne.
Dennis, Mills, (Hon.), Cleburne.
English, Robert D., Glen Rose.
Filardi, Hector H.,
310 W. Chambers, Cleburne.
Hamilton, Con D., Jr., Cleburne.
Harris, Oscar T., Jr., Alvarado.
Jowell, Charlie C., Cleburne.
Kimbro, Robt. W.,
310 W. Chambers, Cleburne.
Knox, Marshall T., Cleburne.
Little, John G., Cleburne.
Marks, Roger E., Glen Rose.
Peters, Joseph F., Jr., Box 431, Alvarado.
Pickens, J. Wendell, Cleburne.
Rice, John S., Jr., Kimbro Clinic, Cleburne.
Shiflett, Roland M., 624 N. Main, Cleburne.
Smyth, Olin T., Jr.,
111 So. Anglin St., Cleburne.
Thomas, Vernon L.,
Grandview Clinic, Grandview.
Whitehouse, Wm. R., (Sec'y.),
310 W. Chambers, Cleburne.
Wright, Glenn R., 310 W. Chambers, Cleburne.
Yater, Robt. E. L., (Hon.), Cleburne
Yater, Tolbert F., (Pres.), Cleburne.

LIMESTONE

Barger, Marius I, 216 N. Sherman, Mexia.
Barrow, W. Burton, Mexia State School, Mexia.
Brewster, Charles H.,
216 N. Sherman, Mexia.
Carrington, Wm. L., Mexia.
Christoffer, O. T., Mexia.
Cox, Stanley, (Sec'y.), Groesbeck.
Edgar, Cecil C., Mexia.
Halbert, Bill L., 315 Main St., Teague.
McKenzie, Casimir P., Mexia.
Wells, David T., Box 1132, Mexia.
Williford, Carl Ed, (Pres.),
216 North Sherman, Mexia.
Wilson, Thelbert R.,
311 North Tyus, Groesbeck.

McLENNAN

Alexander, Boyd D.,
1105 Washington Ave., Waco.
Alexander, Robert B.,
1105 Washington Ave., Waco.
Allen, Homer B., Jr., 400 Main St., McGregor.
Anderson, Gilbert I., 1609 S. 12th St, Waco.
Anspach, Harold M., 1316 Austin Ave., Waco.
Atkins, Neal M., 605 Columbus St., Waco.
Avent, Woodrow M., 1716 Colcord, Waco.
Aynesworth, Horace T., (Hon.),
Box 1492, Waco.
Aynesworth, M. Brian, 105 S. 18th St., Waco.
Barnes, Maurice C., 1310 Austin Ave., Waco.
Baskin, Roy H., 1925 North 25th, Waco.
Bellegie, Nicholas Jr.,
1925 North 25th, Waco.
Berry, George W., 107 S. 18th St., Waco.
Braithwaite, Alfred T., 229 Clifton St., Waco.
Brewer, Jesse H., Jr., 3803 N. 22nd St., Waco.
Brooks, Cleveland H.,
1104 Amicable Bldg, Waco.
Brown, Chadwick G., 211 N. Carpenter, Mart.
Brown, William W., Jr.,
2224 Washington, Waco.
Bryant, George C., (Int.),
2253 Raleigh Dr., Augusta, Ga.
Burgess, John L., 1314 Austin Ave., Waco.
Carlisle, Margil C., (Pres.),
1410 Austin Ave., Waco.
Carter, Marion I., 1318 Austin Ave., Waco.
Catto, C. Gray, 1010 Professional, Waco.
Coffelt, Ralph L., 2320 Columbus, Waco.
Coleman, James A., Jr., 1901 N. 25th, Waco.
Colgin, James H., 2320 Columbus Ave., Waco.
Colgin, Merchant W.,
2320 Columbus Ave., Waco.
Collins, C. T., 2320 Columbus Ave., Waco.
Collins, Lawrence D., 2226 Washington, Waco.
Connally, H. Frank, 1914 Colcord Ave., Waco.
Corbett, Joseph H., 2226 Washington, Waco.
Crosthwait, R. Wilson, 107 S. 18th St., Waco.
Crosthwait, Wm. L., (Hon.),
107 S. 18th St., Waco.
Cumming, Robert, 416 W. 2nd, McGregor.
Cunningham, Perry J.,
1806 Austin Ave., Waco.
Dudgeon, Howard R., Jr.,
2226 Washington, Waco.
Dulaney, Charles H.,
1826 Morrow Ave., Waco.
Dunlap, John C., 2320 Columbus, Waco.
Eller, Thomas O., 1305 16th St., Plano.
Fadal, Richard G., 2425 Ethel Ave., Waco.
Fine, Eldon B., Professional Bldg., Waco.
Flowers, Jack W., 2524 Washington, Waco.
Ford, Walter L., VA Hospital, Waco.
Forsythe, John R., 115 S. 18th St., Waco.
Foy, James D., 1609 South 12th St., Waco.
Friedman, Carl, 604 Med. Arts Bldg., Waco.
Friedman, Leo, 4917 Ridge View, Waco.
Gamble, Charles E., 2524 Washington, Waco.
Gandy, William M., 1710 Colcord Ave., Waco.
Garrett, James M., 1408 Austin Ave., Waco.
Gassler, Robert K., 1710 Colcord, Waco.
Gidney, William H., West.
Goodman, Aubrey L., 2216 Austin Ave., Waco.
Granger, W. Hanson, 1316 Austin Ave., Waco.
Gunter, Marion B., Mart.
Hanks, Robert J., 702 Prof. Bldg., Waco.
Harrell, Joe, 1806 Austin Ave., Waco.
Hejtmancik, James H.,
2313 Washington, Waco.
Henner, Charles M.,
4216 Cedar Mt. Dr., Waco.
Hilliard, Joe B., 1525 N. 15th St., Waco.
Hipps, Herbert E., 1612 Columbus Ave., Waco.
Hoehn, F. William,
2320 Columbus Ave., Waco.
Howard, Stanley P., 312 S. 8th St., Waco.
Husbands, Tom L., 1914 Colcord Ave., Waco.
Jaworski, H., 425 Austin Ave., Waco.
Johnson, Ernest A., 1710 Colcord, Waco.
Kee, John L., 805 Amicable Bldg., Waco.
King, Walter B., Jr.,
2320 Columbus Ave., Waco.
Kingsberry, Lloyd B., Honduras, C. A.
Klatt, Wesley W., Hillcrest Hospital, Waco.
Kleiman, Richard B., 1612 Colcord, Waco.
Kochman, Walter P.,
1717 Columbus Ave., Waco.
Lattimore, John E., Amicable Bldg., Waco.
Locke, Corbet C., Jr., 115 S. 18th St., Waco.
MacRae, Malcolm M,
1905 N. 25th, Waco.
Magid, Moreton A., 1525 Colcord Ave., Waco.
Manske, Arnold O., 1917 Austin Ave., Waco.
Marstaller, Wm. E., 1826 Morrow, Waco.
McMahan, George T., VA Center, Waco.
Mewshaw, R. E. L., 1717 S. 9th St., Waco.
Milam, E. A., (Hon.),
1412 Austin Ave., Waco.
Miller, Claire F., Box 1338, Waco.
Mitchell, Holland C., VA Hospital, Waco.
Montgomery, Hazel I., West.
Morrison, S. Bergen, 2317 Washington, Waco.
Murphey, Paul C., 2320 Columbus Ave., Waco.
Nail, William R., (Hon.), (Dead),
Nichols, Ace E., 2508 Austin, Waco.
Oliver, Tom M., 1722 Colcord Ave., Waco.
Pierce, Billy D., 216 West Oak, West.
Power, Paul H., (Hon.),
1011 Prof. Bldg., Waco.
Reese, Clarence H., Professional Bldg., Waco.
Richey, Harvey M., 1722 Colcord Ave., Waco.
Roche, Buell F., 711 Prof. Bldg., Waco.
Roddy, William N., 115 S. 18th St., Waco.
Ross, Philip H., 3323 Brook Circle, Waco.
Rottner, Mark H., 2223 Austin Ave., Waco.
Sadler, Leslie R., 2320 Columbus Ave., Waco.
Scanio, Thomas J., (Int.),
4518 Waynesboro Dr., Houston.
Schwartze, Erich W., 1609 S. 12th St., Waco.
Scruggs, James H., Jr.,
2223 Austin Ave., Waco.
Shellenberger, C. G., 2524 Washington, Waco.
Shipp, J. Ross, Professional Bldg., Waco.
Shipp, W. R. F., (Hon.), Lorena.
Simpson, Neill O., 111 S. 18th St., Waco.
Slade, Harry W., 2224 Washington, Waco.
Sloan, Jack Q., 1901 N. 25th, Waco.
Smith, C. Collom, 1804 Austin Ave., Waco.
Souther, William L., (Hon.),
811 Prof. Bldg., Waco.
Spark, Milton, (Sec'y.), 121 Dallas, Waco.
Spencer, Shelby C., Professional Bldg., Waco.
Spencer, W. Bruce, 3214 Bosque St., Waco.
Stanislav, F. J., Professional Bldg., Waco.
Stewart, Howard R., 3001 Bellmead Dr., Waco.
Tabb, K. Stewart, 1616 Colcord Ave., Waco.
Tabb, T. Edgar, County Health Dept., Waco.
Talley, John E., 2317 Washington, Waco.
Thompson, John E., McGregor.
Traylor, Clayton J.,
2320 Columbus Ave., Waco.

Trippet, Horace H.,
2320 Columbus Ave., Waco.
van den Sigtenhorst, Andries,
2320 Columbus Ave., Waco.
Warren, Daniel D., 1722 Colcord Ave., Waco.
Weekley, F. Clay, 2122 Austin Ave., Waco.
Wilson, Loyal K., 1303 Colcord Ave., Waco.
Wittstruck, Kenneth P.,
Providence Hosp., Waco.
Wood, James K., 2505 Morrow Ave., Waco.
Wood, R. Spencer, (Hon.),
Professional Bldg., Waco.
Woodward, Joseph W.,
2220 Austin Ave., Waco.
Woolsey, Fleta G., 210 N. 7th St., Waco.
Woolsey, Henry U., 210 N. 7th St., Waco.
Woolsey, William J., 210 N. 7th St., Waco.
Wybourn, Robert C., 1316 Austin Ave., Waco.

MILAM

Barkley, Thomas S., Box 1487, Rockdale.
Crump, Thos. E., Cameron.
Green, Travis C., (Pres.),
730 W. Cameron St., Rockdale.
Hamilton, Lawrence E., Rogers.
Newton, William R., Cameron.
Richards, John T., 602 N. Main St., Rockdale.
Richardson, Sidney H., Box 468, Cameron.
Shapiro, David, Cameron.
Smith, Elmer O., Jr., Cameron.
Swift, Clifford G., Cameron.
Woods, H. S. Jr., 724 W. Bell, Rockdale.
Young, Philip M., (Sec'y.),
602 N. Main, Rockdale.

NAVARRO

Barnebee, James H., Jr.,
205 South 15th, Corsicana.
Bone, Robert D., Box 841, Corsicana.
Brown, Charles H., Jr.,
401 West Collin, Corsicana.
Burnett, Samuel H., (Hon.),
Box 168, Corsicana.
Campbell, Calvin D.,
Phys. & Surg. Clin., Corsicana.
Campbell, Robert L.,
205 S. 15th St., Corsicana.
Carter, William W., (Hon.),
328 S. 31st St., Corsicana.
David, J. Wilson, 401 W. Collin, Corsicana.
Gary, Charles L., Jr.,
214 W. 2nd Ave., Corsicana.
Gibson, Louis E., Box 841, Corsicana.
Griffin, Ben H., Frost.
Griffin, John W., Box 841, Corsicana.
Grizzaffi, Anthony L., (Sec'y.),
205 S. 15th St., Corsicana.
Hamill, Dan B., Box 1356, Corsicana.
Hansford, David P.,
Med. Arts Clinic, Corsicana.
Kelton, Leslie E., Jr., Box 583, Corsicana.
Logsdon, William K., Box 598, Corsicana.
Mayfield, William B.,
Corsicana Hosp. & Clin., Corsicana.
McGary, Lester E., Jr.,
401 West Collin, Corsicana.
Mertz, Robert D., Box 841, Corsicana.
Miller, Dubart, Box 461, Corsicana.
Miller, Will M., Box 1135, Corsicana.
Mitchell, Paul H.,
218 W. Second Ave., Corsicana.
Neese, George E., Frost.
Newton, Earl H., Box 394, Corsicana.
Pannill, Fitzhugh C., Jr.,
Med. Arts Clinic, Corsicana.
Rosen, Bernard, (Pres.),
1205 Columbia Circle, Corsicana.
Sanders, Gurley H., Kerens.
Sanders, Ivan T., Kerens.
Shell, William T., Jr., Box 527, Corsicana.
Sneed, William R., 401 W. Collin, Corsicana.

THIRTEENTH DISTRICT

Dr. Travis Smith, Abilene, Councilor

BAYLOR-KNOX-HASKELL

Balch, Edwin H., Seymour.
Bunkley, E. P., (Hon.), Stamford.
Edwards, T. S., Knox City.
Eiland, David C., Munday.
Frizzell, Thos. P., Knox City.
Markward, Chas. G., (Sec'y.),
Knox City Clinic, Knox City.
Massa, Joseph A., (Pres.),
407 N. Washington, Seymour.
Newsom, Robert L., Munday.
Randal, Chas. M., Jr., Seymour.
Rogers, Madison W., (Hon.), Rule.
Scott, Frank C., Haskell.
Taylor, Wm. M., Goree.
Williams, Temple W., Haskell.
Wilson, Roy E., 407 N. Washington, Seymour.

CLAY-MONTAGUE-WISE

Bryant, David W., Box 428, Bridgeport.
Crumpler, Hulen P., (Sec'y.), Bowie.
Crumpler, Prentice, Jr., Bowie.
Darwin, James T., Decatur.
Dean, Wesley N., (Hon.), Boyd.
Harris, Ewing P., Bowie.
Huddleston, William E.,
Bridgeport Hosp., Bridgeport.
Hurn, Robert E., Henrietta.
Inabnett, W. T., Decatur.
Major, A. D., Box 239, Nocona.
Major, John W., Box 239, Nocona.
Merritt, Ben C., Jr., (Pres.),
Rogers Hospital, Decatur.
Pesek, Edward F., 1301 Halsell, Bridgeport.
Rogers, Thomas G., Decatur.
Squyres, Berry N., Tarrant at Lindsey, Bowie.
Strickland, George E.,
316 West Omega, Henrietta.
Valcik, John H., Decatur.
Wharram, Kenneth J., Box 207, Nocona.

EASTLAND-CALLAHAN-STEPHENS-SHACKELFORD-THROCKMORTON

Addy, Ervin E., Jr., 1106 W. 6th, Cisco.
Ball, D., Cisco.
Ballew, Charles H., 900 W. 8th St., Cisco.
Bradley, Ben H., Rising Star Hosp., Rising Star.
Brazda, A. W., Box 133, Ranger.
Brogdon, William M., (Pres.),
Blackwell Hosp., Gorman.
Brown, Audie A., Gorman.
Bulgerin, Harold J.,
507 Connelle St., Eastland.
Cartwright, H. H., Breckenridge.
Ford, T. Carroll, P. O. Box 7, Breckenridge.
Goodall, Edwin, 109 E. Dyer, Breckenridge.
Graham, Emmett L., Cisco.
Howle, Thomas M., Post Office Bldg., Albany.
Lawrence, Jim T., Breckenridge.
Mays, Anthony W., Jr.,
Throckmorton Clin., Throckmorton.
Mims, Douglas L., 211 N. Austin, Ranger.
Nacol, William S., Jr., Throckmorton.
Payne, Frank C., 111 S. Miller, Breckenridge.
Rodgers, David V., Gorman.
Stubblefield, M. L., Box 1046, Baird.
Townsend, Edwin R., Eastland.
Treadwell, Mose A., Jr., (Sec'y.),
404 W. Commerce, Eastland.
Watkins, Wirter P.,
c/o The Ranger Cl., Ranger.
Whittington, James C., Eastland.

PALO PINTO-PARKER-YOUNG-JACK-ARCHER

Abney, Thomas B., Box 285, Weatherford.
Allen, Platt L., Weatherford.
Allensworth, John C.,
208 NW 2nd St., Mineral Wells.
Allensworth, William B., (Sec'y.),
208 NW 2nd St., Mineral Wells.
Conner, Paul K., Jacksboro.
Divine, Blaine, Graham.
Eidson, Jack L.,
614 Palo Pinto St., Weatherford.
Gafford, Gordon M.,
415 NW 2nd St., Mineral Wells.
Gowan, R. E. L., Graham.
Griffin, B. B., Graham.
Griffin, H. E., Graham.
Harrell, Fred S., Olney.
Jordan, Robbie C., Mineral Wells.
Kenner, Joanne,
208 NW Second St., Mineral Wells.
Lasater, Waldo B., Box 77, Mineral Wells.
Lovett, Raymond E., Olney.
Mask, William G., (Pres.),
237 W. Archer, Jacksboro.
McCall, James D.,
Baker Hotel Bldg., Mineral Wells.
McCloud, Ben L., Mineral Wells.
McClure, C. C., Jacksboro.
McElroy, Delmer G.,
213 W. Archer, Jacksboro.
McKinney, Hugh C., (Hon.), Olney.
Merrick, John B., Weatherford.
Nelson, Joe T., Weatherford.
Oates, K. D., Graham.
O'Quin, William A.,
Baker Hotel Bldg., Mineral Wells.
Padgett, W. O., Graham.
Patterson, Andrew M., Box 70, Mineral Wells.
Pedigo, Paul C., Strawn.
Roan, John L., 106 South Main, Weatherford.
Roberson, John F., (Hon.), Gordon.
Rosser, V. O., Jr., 614 Third St., Graham.
Russell, Earl M., Weatherford.
Shilling, Harold C., 805 Cherry St., Graham.
Smith, John E., 205 W. Spring, Weatherford.
Smith, Robert H., Palo Pinto.
Spears, Jean Wiley, Graham.
Spratt, John T., (Hon.), Mingus.
Whalen, Carl H., Weatherford.
Wheelis, Brewer D., Jacksboro.
Williams, Charles R., Mineral Wells.
Yeager, Edward F.,
Baker Hotel Bldg., Mineral Wells.

TARRANT

Adams, Kenneth P.,
1601 E. Abram St., Arlington.
Allen, Daisy E., (Hon.),
2256 Fifth Avenue, Fort Worth.
Alliston, Wiley S., Jr.,
701 5th Ave., Fort Worth.
Anderson, Herman W., Jr.,
715 Fifth Avenue, Fort Worth.
Andujar, John J.,
2951 Benbrook Blvd., Fort Worth.
Anthony, Ernest E., Jr.,
409 Med. Arts Bldg., Fort Worth.
Anthony, Walter P., Jr.,
705 Fifth Avenue, Fort Worth.
Archer, Maurice C.,
1216 Pennsylvania, Fort Worth.
Armstrong, Wm. F.,
1400 8th Avenue, Fort Worth.
Aurin, Fred B., 1216 Pennsylvania, Fort Worth.
Auringer, Arthur J., 410 W. Abram, Arlington.
Austin, Carl M., 1325 S. Main, Fort Worth.
Avery, Jack W., 515 S. Summit, Fort Worth.
Axtell, Earl C., (Hon.),
5741 Electric Ave., La Jolla, Calif.
Bailey, Noel R.,
1506 W. Terrell St., Fort Worth.
Baker, Robert G.,
715 Med. Arts Bldg., Fort Worth.
Ball, Bert C., 604 Doctors Bldg., Fort Worth.
Ballinger, Thos. I.,
3309 N E 28th St., Fort Worth.
Banker, Harry W., Box 1719, Fort Worth.
Barcus, James R.,
708 S. Henderson, Fort Worth.
Barcus, Wm. Shelton,
708 S. Henderson, Fort Worth.
Barker, Robert C., 1501 Summit, Fort Worth.
Barnes, Chas. K.,
Neil P. Anderson Bldg., Fort Worth.
Barrett, Isaac P.,
3210 W. Lancaster, Fort Worth.
Barrier, Chas. W.,
Medical Arts Bldg., Fort Worth.
Bausman, Charles H., Jr.,
1958 E. Park Row, Arlington.
Beard, Bruce H.,
2140 Warner Rd., Fort Worth.
Beasley, C. Harold, 711 Fifth Ave., Fort Worth.
Beasley, Grace A., 3226 Odessa, Fort Worth.
Beaton, Hugh,
1316 Med. Arts Bldg., Fort Worth.
Beavers, Geo. H., Jr.,
714 S. Lake St., Fort Worth
Begley, Grant F.,
1415 Pennsylvania, Fort Worth.
Bell, J. Ardis, 1216 Pennsylvania, Fort Worth.
Bennett, Jerrell,
650 S. Henderson, Fort Worth.
Bertram, Harold F.,
650 Fifth Ave., Fort Worth.
Bibby, Douglas E.,
1217 W. Cannon, Fort Worth.
Bickel, Robert D.,
Professional Bldg., Fort Worth.
Bida, John F., 715 W. Abram, Arlington.
Bishop, Alton A.,
2501 W. Berry St., Fort Worth.
Black, Thos. W., 808 8th Ave., Fort Worth.
Blaha, Frank J.,
2404 W. Seminary Dr., Fort Worth.
Bobo, Zack, Jr., 311 S. Center, Arlington.
Bolch, Alfred P.,
1004 Briarwood, Arlington.
Boles, Truett C., 600 W. Park Row, Arlington.
Boluch, John J., 108 Denver Trail, Azle.
Bond, Tom B.,
815 Med. Arts Bldg., Fort Worth.
Bonelli, Victor E., (Inac.),
1409 Med. Arts Bldg., Fort Worth.
Bontley, Paul T., 112 Oriole Dr., Arlington.
Boren, Darrell W.,
3341A Winthrop, Fort Worth.
Borg, Fritz H., 800 S. Lake St., Fort Worth.

Boston, Don Wayne,
3101 Travis Ave., Fort Worth.
Bowden, Andy J., Jr.,
650 S. Henderson, Fort Worth.
Boyd, Craig H., 554 S. Summit, Fort Worth.
Bradshaw, Wilber V., Jr.,
1800 University Dr., Fort Worth.
Braselton, Chas. W., Jr.,
1050 W. Dashwood, Fort Worth.
Brasher, Ray V.,
1008 W. Peter Smith, Fort Worth.
Brentlinger, Robert W.,
1005 Sherwood, Arlington.
Brock, Bill L., 307 New York, Arlington.
Brock, Ernest H., (Inac.),
707 Hawkins, Fort Worth.
Bronstad, Morris T., Jr.,
3101 Winthrop, Fort Worth.
Brooks, James W., 5019 Nolan, Fort Worth.
Brooks, Marion J.,
417 East 9th St., Fort Worth.
Brous, Marion W.,
1012 S. Henderson, Fort Worth.
Brown, Arthur, 1015 Lamar, Fort Worth.
Brown, Clarence E.,
209 Waters St., Mansfield.
Brown, W. Porter,
1106 Med. Arts Bldg., Fort Worth.
Brownfield, Jack D.,
806 S. Lake St., Fort Worth.
Bruner, Cavan B., (Mil.),
5754 Blue Ridge Dr., Fort Worth.
Burgess, Richard M.,
3226 E. Rosedale, Fort Worth.
Burgess, Richard M., Jr.,
3226 E. Rosedale, Fort Worth.
Burnett, Jesse M., 415 East Sixth, Fort Worth.
Bursey, Leroy, 3101 Winthrop, Fort Worth.
Bussey, Thomas B.,
1101 Med. Arts Bldg., Fort Worth.
Butler, Alan W., Jr.,
1001 5th Ave., Fort Worth.
Bynum, Frank L., 650 Fifth Ave., Fort Worth.
Campbell, J. Franklin, 1410 Pruitt, Fort Worth.
Campbell, Ralph E., (Mil.),
Ireland Army Hosp., Fort Knox, Ky.
Carpenter, Nathan C.,
Ft. Worth Nat. Bk. Bg., Fort Worth.
Carr, Robert E., 800 Fifth Ave., Fort Worth.
Carter, Peter J.,
6721 Telephone Rd., Fort Worth.
Carter, Willis H.,
1216 Pennsylvania, Fort Worth.
Cayce, John H.,
1302 Med. Arts Bldg., Fort Worth.
Chambers, James O.,
1519 Pennsylvania, Fort Worth.
Chapman, Martha J.,
5808 E. Belknap, Fort Worth.
Chapman, Robert E.,
5808 E. Belknap, Fort Worth.
Childs, Tilden L., Jr.,
3102 Greene, Fort Worth.
Chorn, Etheredge H.,
554 S. Summit, Fort Worth.
Church, John M.,
1221 W. Lancaster, Fort Worth.
Claunch, Dewitt
900 Eighth Ave., Fort Worth.
Clayton, Chas. F.,
1001 Med. Arts Bldg., Fort Worth.
Clayton, Irvin,
1017 Med. Arts Bldg., Fort Worth.
Clifford, William S.,
1017 Pennsylvania, Fort Worth.
Cochran, J. Robert, 717 Fifth Ave., Fort Worth.
Cohen, Frank, 712 S. Henderson, Fort Worth.
Cohn, Robert L., 312 W. Hurst Blvd., Hurst.
Coleman, Rogers K., (Int.),
1500 S. Main, Fort Worth.
Coleman, Thos. J.,
1221 W. Lancaster, Fort Worth.
Collier, Julius W.,
1067 W. Magnolia, Fort Worth.
Colvin, Joseph W.,
5201 Camp Bowie Blvd., Fort Worth.
Compere, Dolphus E.,
1415 Pennsylvania, Fort Worth.
Conner, Cooper M.,
1055 West Terrell, Fort Worth.
Cook, Percy L., 209 Waters, Mansfield.
Cook, Willis G., (Hon.),
3625 Park Hill Dr., Fort Worth.
Council, Francis E.,
1404 Pennsylvania, Fort Worth.
Crabb, McKinley H.,
1710 Med. Arts Bldg., Fort Worth.
Crawford, William M.,
612 Sixth Ave., Fort Worth.
Cross, Thomas J.,
1414 Pennsylvania, Fort Worth.
Cummins, John B., (Hon.),
311 Moore Bldg., Fort Worth.
Cunningham, Ernest S., Jr.,
921 8th Ave., Fort Worth.
Daly, Jack E., 1325 S. Main St., Fort Worth.
Darnell, Ruth Little,
3125 Handley Dr., Fort Worth.
Daugherty, Frank J.,
515 South Summit, Fort Worth.
Davenport, Emory, (Sec'y.),
Box 1719, Fort Worth.
Davis, Edwin, Jr.,
1216 Pennsylvania, Fort Worth.
Day, Giles W., 910 Eighth Ave., Fort Worth.
Deaton, Hobart O.,
616 Sixth Ave., Fort Worth.
DeBusk, Jack S.,
1001 Pennsylvania, Fort Worth.
Dees, Doyce B., Jr., (Mil.),
3948 Weyburn Dr., Fort Worth.
Diamond, William D.,
1000B Fifth Ave., Fort Worth.
Dingwerth, Frank S.,
1601 E. Abram, Arlington.
Ditto, Hugh H.,
1307 Pennsylvania, Fort Worth.
Doss, A. Keller,
Medical Arts Bldg., Fort Worth.
Doss, Doyle J.,
3427 E. Lancaster, Fort Worth.
Douglass, Hal C., (Inac.),
3005 University Dr., Fort Worth.
Douthit, Thomas E., Jr., (Mil.),
APO 731, Seattle, Wash.
Dunn, Nelson L., (Inac.),
Medical Arts Bldg., Fort Worth.
Duringer, William C., (Hon.),
3729 Lenox Drive, Fort Worth.
Edwards, Walter T.,
4104 E. Lancaster, Fort Worth.
Ellis, Joe B.,
3805 Southwest Blvd., Fort Worth.
Emery, Oscar J.,
406 Med. Arts Bldg., Fort Worth.
Eschenbrenner, John W.,
1216 Pennsylvania, Fort Worth.
Estes, Ben P., (Int.), Box 398, Granbury.
Etier, Edgar L., Jr.,
310 Prof. Bldg., Fort Worth.
Ezell, Edgar S., Box 1719, Fort Worth.
Farley, James A., 1000 Fifth Ave., Fort Worth.
Fershtand, John B.,
1501 Summit, Fort Worth.
Fitzwilliam, C. Dennis,
800 Fifth Ave., Fort Worth.
Flood, William E., (Pres.),
Medical Arts Bldg., Fort Worth.
Funk, Theron H.,
501 S. Summit, Fort Worth.
Furman, John M., Jr.,
404 Med. Arts Bldg., Fort Worth.
Gambill, Alice F.,
1601 Clover Lane, Fort Worth.
Gardiner, Henry G., Jr.,
Box 1719, Fort Worth.
Garnett, John W., Jr.,
1016 W. Cannon, Fort Worth.
Gentling, Allen A.,
5109 Bryce, Fort Worth.
Gibbs, Donald S., 650 Fifth Ave., Fort Worth.
Gilliland, Lloyd N., Jr.,
424 S. Summit, Fort Worth.
Godley, Louie O., (Hon.),
2129 Park Place, Fort Worth.
Goggans, Albert M.,
811 5th Ave., Fort Worth.
Goldberg, Abraham I.,
Burk Burnett Bldg., Fort Worth.
Goldberg, Morton N.,
Burk Burnett Bldg., Fort Worth.
Gooch, Frank B.,
1009 Pennsylvania, Fort Worth.
Goodman, Thomas L., (Hon.),
1933 Forest Park, Fort Worth.
Grammer, James H.,
1400 8th Ave., Fort Worth.
Grammer, Richard B.,
1400 8th Ave., Fort Worth.
Gray, Billy N., 1517 E. Berry, Fort Worth.
Greines, Abe,
1549 N. Main St., Fort Worth.
Greve, Anna M.,
1210 Virginia Pl., Fort Worth.
Grice, Thomas W.,
1312 Med. Arts Bldg., Fort Worth.
Griffin, Anderson A.,
411½ East 9th, Fort Worth.
Griffin, Otho P., 800 Fifth Ave., Fort Worth.
Grogan, Oscar R., 3200 Avondale, Fort Worth.
Grogan, Roy L., 921 Fifth Ave., Fort Worth.
Grunow, Otto H., 650 5th Ave., Fort Worth.
Guinn, James E.,
411½ East 9th, Fort Worth.
Gwozdz, Feliks, P. O. Box 1719, Fort Worth.
Haffke, Oscar W.,
1017 Pennsylvania, Fort Worth.
Hageman, Phyllis M.,
1425 Pennsylvania, Fort Worth.
Haggard, Fred A., (Hon.),
Westbrook Hotel, Fort Worth.
Hall, Ewin P., Jr.,
402 Med. Arts Bldg., Fort Worth.
Hallmark, James A.,
951 W. Magnolia, Fort Worth.
Halpin, Frank W., 3500 W. 7th, Fort Worth.
Hardwick, B. Randol,
3341A Winthrop, Fort Worth.
Hardwick, Jack F.,
3341A Winthrop, Fort Worth.
Harle, Harold L.,
4720 E. Lancaster, Fort Worth.
Harris, Charles H., (Hon.), (Dead).
Harris, Chas. H., II,
1501 S. Summit, Fort Worth.
Harris, J. Robert,
1115 Pennsylvania, Fort Worth.
Harrison, Edwin S.,
2014 N. Riverside, Fort Worth.
Hartnett, Dalton C.,
800 Fifth Ave., Fort Worth.
Hatch, Garth S., (Int.),
Harris Hospital, Fort Worth.
Hawker, Laverne J.,
1556 W. Magnolia, Fort Worth.
Hawkins, Chas. P.,
1524 Pruitt St., Fort Worth.
Hayes, Charles F., (Hon.),
1609 Harrington, Fort Worth.
Head, William M.,
717 Fifth Ave., Fort Worth.
Heberle, James P., P. O. Box 597, Burleson.
Heinrichs, Andrew N.,
554 S. Summit, Fort Worth.
Helbing, Hugh V.,
1549 N. Main St., Fort Worth.
Hendrix, Wm. C., Jr.,
800 Fifth Ave., Fort Worth.
Henry, Raymond L., (Mil.),
5060th USAF Hosp., Seattle, Wash.
Hewatt, John W.,
3301 E. Rosedale, Fort Worth.
Hicks, Chas. E., 3101 Winthrop, Fort Worth.
Hiett, Carey, 815 5th Ave., Fort Worth.
Higgins, Wm. P., Jr.,
501 Med. Arts Bldg., Fort Worth.
Holmes, James E.,
1606 Med. Arts Bldg., Fort Worth.
Holmgren, Robert B.,
1501 Pruitt, Fort Worth.
Holsapple, Cortell K.,
1221 W. Lancaster, Fort Worth.
Hooker, James F., III,
1111 Pennsylvania, Fort Worth.
Hopkins, Glenn A.,
301 W. Central, Fort Worth.
Horn, William S., Jr.,
650 Fifth Ave., Fort Worth.
Howard, Rex J.,
930 Fifth Ave., Fort Worth.
Howard, Rex Z., Box 865, Fort Worth.
Huffman, Andrew M.,
1201 Hemphill St., Fort Worth.
Hugman, George R., Jr.,
Leake Cl. & Hosp., Gladewater.
Hulsey, Sim, 701 5th Ave., Fort Worth.
Hutcheson, George O.,
1105 Pennsylvania, Fort Worth.
Innis, E. Renshaw, 900 8th Ave., Fort Worth.
Isaacks, Hub E.,
1415 Pennsylvania, Fort Worth.
Isbell, Marney C., 3908 Earl, Fort Worth.
Jackson, Atras E.,
1112 Med. Arts Bldg., Fort Worth.
Jackson, Holland T.,
1602 Med. Arts Bldg., Fort Worth.
Jacobson, Bruce K.,
7211 Grapevine Hwy., Fort Worth.
Jagoda, Samuel, 1501 Summit, Fort Worth.
Jenkins, Wesley N.,
3102 Greene Ave., Fort Worth.
Jermyn, John W.,
6717 Grapevine Hwy., Fort Worth.
Jernigan, C. Richard, 708 E. Abram, Arlington.
Jernigan, John M.,
1101 W. Berry, Fort Worth.
Jernigan, Lane M.,
1101 W. Berry, Fort Worth.
Jewell, George W., Jr.,
5201 River Oaks Blvd., Fort Worth.
Johnson, Clive R.,
1216 Pennsylvania, Fort Worth.
Johnson, F. Melvin,
7112 Camp Bowie, Fort Worth.
Johnston, Dewey W.,
901 W. Leuda St., Fort Worth.

Jones, Shellie J., Jr., (Mil.),
2820 S. Jennings, Fort Worth.
Jordan, Carl F.,
1800 University Dr., Fort Worth.
Jordan, Jack, 3203 Bilglade, Fort Worth.
Jorns, Kenneth L., 424 S. Summit, Fort Worth.
Kauffmann, Adolph F.,
707 Fifth Ave., Fort Worth.
Keating, Joseph L.,
1608 Med. Arts Bldg., Fort Worth.
Keith, Joseph M., 501 S. Summit, Fort Worth.
Kelly, Gordon B.,
1001 Pennsylvania, Fort Worth.
Kerr, Walter C. H.,
1511 Med. Arts Bldg., Fort Worth.
Key, William F., (Hon.),
3229 Wabash, Fort Worth.
Kibbie, Horace K.,
2309 Medford Ct., E, Fort Worth.
Kibbie, Kent V., (Hon.),
Medical Arts Bldg., Fort Worth.
King, Gerald A.,
3951 E. Lancaster, Fort Worth.
Kingsbury, Herman B.,
316 Med. Arts Bldg., Fort Worth.
Kleuser, Lawrence P.,
930 Fifth Ave., Fort Worth.
Knox, Warren G.,
2905 Vaughn Blvd., Fort Worth.
Kramer, John T., Jr.,
5050 E. Belknap, Fort Worth.
Kyger, E. Ross, Jr.,
1101 Pennsylvania, Fort Worth.
Lace, W. Ted,
1001 Pennsylvania, Fort Worth.
Lacy, Geo. W.,
515 Med. Arts Bldg., Fort Worth.
Ladd, Arnett D.,
306 W. Broadway, Fort Worth.
Lancaster, Edgar L.,
1011 West NW Hwy, Grapevine.
Lancaster, Minnie L.,
1011 West N W Hwy., Grapevine.
Lange, Arthur A.,
508 Med. Arts Bldg., Fort Worth.
Lankford, Frances L. P.,
600 W. Park Row, Arlington.
Lauderdale, Thos. L., 554 Summit, Fort Worth.
Leaffer, Harry,
4208 Rainier Ct., Fort Worth.
Lees, Chas. R.,
805 Med. Arts Bldg., Fort Worth.
Lemon, Robert G.,
811 5th Ave., Fort Worth.
Lenox, Walter R.,
800 Fifth Ave., Fort Worth.
Leon, William R.,
1001 Pennsylvania, Fort Worth.
Leverett, Jack K., Convair, Fort Worth.
Levy, Louis J., 918 Eighth Ave., Fort Worth.
Ligon, C. Wayne (Int.),
St. Joseph's Hosp., Fort Worth.
Lindsay, John F., Jr.,
1216 Pennsylvania, Fort Worth.
Lindsey, Jene H., (Int),
Harris Hospital, Fort Worth.
Lipscomb, Cuvier P.,
918 Eighth Ave., Fort Worth.
Littlepage, Henry B.,
1503 Med. Arts Bldg., Fort Worth.
Looney, Robert H. Jr.
1505 Med. Arts Bldg., Fort Worth.
Lorimer, Wishard S. (Hon.)
3851 Winslow Dr., Fort Worth.
Lorimer, Wishard S., Jr.,
901 W. Leuda, Fort Worth.
Luke, Edward A.,
3112 Handley Dr., Fort Worth.
Lyle, Judge M.,
Trans. Amer. Life Bldg., Fort Worth.
Maddox, Stephen G., Jr.,
5216 W. Freeway, Fort Worth.
Mallard, Robert S.,
1216 Pennsylvania, Fort Worth.
Malone, James D.,
424 S. Summit, Fort Worth.
Marietta, John S.,
1115-B Pennsylvania, Fort Worth.
Marrow, William S.,
1519 Pennsylvania, Fort Worth.
Marrs, Walford D.,
306 W. Broadway, Fort Worth.
Matheson, Dan N.,
Medical Arts Bldg., Fort Worth.
Mayo, Talmadge D., Jr.,
921 5th Ave., Fort Worth.
McBride, James O.,
513 Med. Arts Bldg., Fort Worth.
McCarroll, Molloy C.,
1004 W. Peter Smith, Fort Worth.
McCollum, Chas. H., Jr.,
1100 Pennsylvania, Fort Worth.
McConnell, John A., (Inac.), Azle.
McDaniel, Thos. W., Jr.,
1410 Med. Arts Bldg., Fort Worth.
McDonald, Earl D., 1320 S. Collins, Arlington.
McDonald, Henry C., Jr.,
918 8th Avenue, Fort Worth.
McDonald, Robert P.,
1050 W. Dashwood, Fort Worth.
McKay, Jack M., 1504 E. Abram, Arlington.
McKee, Frank, 1016 W. Cannon, Fort Worth.
McKee. Frank S.,
1016 W. Cannon, Fort Worth.
McKenzie, Walten H.,
800 S. Lake St., Fort Worth.
McKinney, William W.,
800 Fifth Avenue, Fort Worth.
McKnight, W. Hodges,
Amon Carter Field, Fort Worth.
McLeroy, William B., Box 56-A, Azle.
McVeigh, Joseph F.,
306 W. Broadway, Fort Worth.
Mitchell, D. Gatlin,
1604 Med. Arts Bldg., Fort Worth.
Mitchell, Jerrell L.,
3800 Camp Bowie Blvd., Fort Worth.
Monaghan, Johnnie E., Jr.,
1009 Pennsylvania, Fort Worth.
Moore, Louis G., 1320 S. Collins, Arlington.
Moorman, Warren W.,
901 W. Leuda, Fort Worth.
Moreton, Robert D.,
1217 W. Cannon, Fort Worth.
Morgan, William H.,
1109 Pennsylvania, Fort Worth.
Morphis, Oscar L.,
1942 Fairmount, Fort Worth.
Morris, Abner J., 3432 W. 7th St., Fort Worth.
Murchison, St. Julien R.,
803 Med. Arts Bldg., Fort Worth.
Murphy, James D.,
1556 W. Magnolia, Fort Worth.
Mycoskie, Bernard J.,
3rd and Southwest, Arlington.
Myers, Theodore B.,
901 W. Cannon, Fort Worth.
Myers, William T.,
Westcliff Center, Fort Worth.
Neal, Durwood E.,
1556 W. Magnolia, Fort Worth.
Needham, Robert H., (Hon.),
Continental Life Bldg., Fort Worth.
Neighbors, DeWitt, 701 5th Ave., Fort Worth.
Neil, William H.,
815 Med. Arts Bldg., Fort Worth.
Nesbit, Preston M., 309 E. Main, Arlington.
Nifong, Harry D., (Inac.), Mansfield.
Nyman, Randall D.,
1015 Pennsylvania, Fort Worth.
O'Bannon, Roscoe P.,
650 Fifth Ave., Fort Worth.
Olcott, Eugene D.,
1216 Pennsylvania, Fort Worth.
O'Reilly, John J., (Hon.),
19 Peak Road, Austin.
Ort, William O.,
1017 W. Terrell Ave., Fort Worth.
Owen, May, Box 1719, Fort Worth.
Patterson, Bertha M., (Hon.),
905 College Ave., Fort Worth.
Patterson, John B.,
415 Med. Arts Bldg., Fort Worth.
Petta, Walter B.,
1556 W. Magnolia, Fort Worth.
Phillips, Oliver M.,
1221 W. Lancaster, Fort Worth.
Phillips, William G., 3021 Race, Fort Worth.
Pillow, David J.,
7211 Grapevine Hwy., Fort Worth.
Ploussard, John H., 1114 E. Abram, Arlington.
Potts, John, (Hon.),
301 Danciger Bldg., Fort Worth.
Powell, J. Randolph, (Int.),
1500 S. Main, Fort Worth.
Price, Earl P., Jr.,
1000 W. Petersmith, Fort Worth.
Price, Richard V.,
1216 Pennsylvania, Fort Worth.
Price, Sidney A.,
1216 Pennsylvania, Fort Worth.
Prine, John M., 1112 E. Abram St., Arlington.
Prudhomme, Eck G., Jr.,
5153 River Oaks Blvd., Fort Worth.
Pumphrey, Andrew B.,
1701 Med. Arts Bldg., Fort Worth.
Ramey, Paul M.,
1615 Med. Arts Bldg., Fort Worth.
Rape, Joe G., 715 W. Abrams, Arlington.
Rapfogel, Irving,
1414 W. Humbolt, Fort Worth.
Rathgeber, Van D.,
1305 Med. Arts Bldg., Fort Worth.
Readinger, Ivan H.,
1000 Fifth Ave., Fort Worth.
Reeves, Ernest E.,
1507 Med. Arts Bldg., Fort Worth.
Reeves, Leopold H., (Emer.),
1416 Med. Arts Bldg., Fort Worth.
Rehfeldt, Frederick C.,
1001 Pennsylvania, Fort Worth.
Reidland, Kenneth E.,
918 Eighth Ave., Fort Worth.
Renshaw, Horace S.,
914 W. Cannon, Fort Worth.
Richards, John H.,
4222 Birchman St., Fort Worth.
Richardson, James J., 1519 Pruitt, Fort Worth.
Riddell, J. Murray, Jr.,
800 Fifth Avenue, Fort Worth.
Riddle, Charles H.,
7305 Briley Drive, Fort Worth.
Riley, Jack C., 1425 Pennsylvania, Fort Worth.
Rimmer, Raymond J.,
1009 Pennsylvania, Fort Worth.
Risley, Thomas W.,
5153 River Oaks Blvd., Fort Worth.
Roan, Leon N., 4727 Camp Bowie, Fort Worth.
Robinson, Charles, 811 5th Ave., Fort Worth.
Rockwell, Paul A.,
1216 Pennsylvania, Fort Worth.
Rogers, Ernest D., 515 S. Summit, Fort Worth.
Rogers, Riveire L. C., (Hon.),
2501 Fifth Ave., Fort Worth.
Rohrer, Vern, 800 Fifth Ave., Fort Worth.
Ross, Nealie E., 701 5th Ave., Fort Worth.
Rubin, Norman L., 800 Fifth Ave., Fort Worth.
Rumph, Mal, 705 Med. Arts Bldg., Fort Worth.
Rush, Charles A., Jr.,
4625 Vance Rd., Fort Worth.
Rutledge, Art H., Box 1719, Fort Worth.
Rutledge, Robb H., 800 Fifth Ave., Fort Worth.
Savage, Hugh W., 815 Fifth Ave., Fort Worth.
Savage, James Munroe, Azle Clinic, Azle.
Schaffer, Richard C.,
800 Fifth Ave., Fort Worth.
Schenck, Chas. P., (Hon.),
3117 Stadium Dr., Fort Worth.
Schoolfield, Emmett C.,
Insurance Bldg., Fort Worth.
Schoonover, Frank S., Jr.,
608 S. Adams, Fort Worth.
Schwarz, Edwin G.,
712 S. Henderson, Fort Worth.
Scroggie, Val D.,
1001 Pennsylvania, Fort Worth.
Sealy, Wm. Burgess,
1707 Med. Arts Bldg., Fort Worth.
Sehested, Herman C.,
815 Med. Arts Bldg., Fort Worth.
Sewell, John H.,
1221 W. Lancaster, Fort Worth.
Sewell, Robert L.,
1221 W. Lancaster, Fort Worth.
Shaw, Marie L., P. O. Box 1719, Fort Worth.
Shaw, R. Preston, (Mil.),
918 E. 37th, Lubbock.
Sheddan, Frank G., (Inac.),
1313 Sinclair Bldg., Fort Worth.
Sheinberg, Philip, 400 W. Hurst Blvd., Hurst.
Shelley, Harold J.,
1000 Fifth Ave., Fort Worth.
Shields, Thos. L.,
1216 Pennsylvania, Fort Worth.
Shoemaker, Thos. J. W.,
Stockyard Natl. Bldg., Fort Worth.
Short, James W., 811 Fifth Ave., Fort Worth.
Siddons, Geo. Y.,
1307 Pennsylvania, Fort Worth.
Silva, Samuel, 1301 N. Main, Fort Worth.
Skokan, William,
Medical Arts Bldg., Fort Worth.
Small, David E., 911 Sixth Ave., Fort Worth.
Smith, G. Con, 650 Fifth Ave., Fort Worth.
Smith, J. Ronald,
1607 Med. Arts Bldg., Fort Worth.
Smith, Jack C., 800 Fifth Ave., Fort Worth.
Smith, Newton D.,
1702 Med. Arts Bldg., Fort Worth.
Smith, Stanley C.,
1216 Pennsylvania, Fort Worth.
Smith, Wallace B., (Dead).
Snyder, Frank L., 304 Virginia Pl., Fort Worth.
Snyder, Roy E.,
203 Med. Arts Bldg., Fort Worth.
Spackman, Edgar W,
General Delivery, San Juan.
Stadler, Earl W., 800 Fifth Ave., Fort Worth.
Steger, Joseph H.,
923 Pennsylvania, Fort Worth.
Steinberger, Eugene,
901 W. Cannon, Fort Worth.
Stewart, George A., Jr.,
1015 Pennsylvania, Fort Worth.
Stouffer, James G.,
1506 W. Terrell Ave., Fort Worth.

Stout, Sidney E., 650 Fifth Ave., Fort Worth.
Stow, Robert C., Jr.,
306 W. Broadway, Fort Worth.
Sumner, Wendell W., 600 Bailey, Fort Worth.
Swift, William B., 1501 Summit, Fort Worth.
Swords, H. Logan,
301 W. Central Ave., Fort Worth.
Tadlock, Marvin E.,
Burk Burnett Bldg., Fort Worth.
Tatum, William C.,
1304 Med. Arts Bldg., Fort Worth.
Taylor, Elbert D.,
5534 E. Belknap, Fort Worth.
Taylor, Elizabeth A., Box 1719, Fort Worth.
Taylor, Thomas U., II,
1009 Pennsylvania, Fort Worth.
Teague, William H.,
4420 N. E. 28th St., Fort Worth.
Terrell, Blanche O.,
1425 Pennsylvania, Fort Worth.
Terrell, Caleb O., Jr.,
1015 Pennsylvania, Fort Worth.
Terrell, Chas. J., 602 W. 10th St., Fort Worth.
Terrell, Truman C., Box 1719, Fort Worth.
Thomas, Henry W., Jr.,
1612 N. W. 28th St., Fort Worth.
Thomas, Hiram C.,
1055 W. Terrell, Fort Worth.
Thomason, Thos. H.,
1226 Pennsylvania, Fort Worth.
Thompson, Burl V.,
1400 8th Ave., Fort Worth.
Tipps, D. Conway,
1100 Pennsylvania, Fort Worth.
Toppin, Bruce E.,
3427 E. Lancaster, Fort Worth.
Tottenham, John W., (Hon.),
554 S. Summit, Fort Worth.
Tottenham, John W., Jr.,
3706 Tulsa Way, Fort Worth.
Touzel, Cecil S. E.,
1111 Pennsylvania, Fort Worth.
Tucker, John T., 404 West 3rd St., Fort Worth.
Tucker, John T., Jr.,
404 West 3rd St., Fort Worth.
Tunstill, James W., 1501 Summit, Fort Worth.
Turner, Jack L., 515 S. Summit, Fort Worth.
Van Zandt, Isaac L., 915 5th Ave., Fort Worth.
Viard, Walter S., Jr.,
1901 N. E. 28th St., Fort Worth.
Walker, James N.,
5216 W. Freeway, Fort Worth.
Walker, Webb,
703 Med. Arts Bldg., Fort Worth.
Wallace, E. Frank, 715 W. Abram, Arlington.
Wallace, John L., Jr.,
P. O. Box 11435, Fort Worth.
Walsh, Edmund N., 1410 Pruitt, Fort Worth.
Ware, Drue O. D.,
1302 W. Magnolia, Fort Worth.
Watson, Asa C., Jr., 815 5th Ave., Fort Worth.
West, Walter B.,
951 W. Magnolia, Fort Worth.
Westfall, Cad B., 1501 Summit, Fort Worth.
White, Richard J.,
W. T. Waggoner Bldg., Fort Worth.
Wier, Edward M.,
1401 W. Rio Grande, Fort Worth.
Wiggins, J. Kenneth,
1216 Pennsylvania, Fort Worth.
Wiggins, John A.,
1105 Pennsylvania, Fort Worth.
Willess, Hersel F., 800 Fifth Ave., Fort Worth.
Williams, Claude,
815 Med. Arts Bldg., Fort Worth.
Williams, Marion F.,
1055 W. Terrell, Fort Worth.
Willis, Selwyn A.,
Third and Southwest, Arlington.
Willis, Virginia G.,
2102 King Ave., Fort Worth.
Wilson, Edwin B., Jr.,
1501 Summit, Fort Worth.
Wilson, Stephen W.,
914 Med. Arts Bldg., Fort Worth.
Winterringer, James R.,
1216 Pennsylvania, Fort Worth.
Wise, Joe R., 1519 Pennsylvania, Fort Worth.
Witt, Roger W.,
312 Crestwood Dr., Fort Worth.
Wollenman, Oscar J., Jr.,
1724 Martel, Fort Worth.
Womack, Harry H.,
1424 W. Petersmith, Fort Worth.
Womble, Joe D., 1112 E. Abram, Arlington.
Wood, William W., Jr.,
811 Med. Arts Bldg., Fort Worth.
Woodward, Cicero S.,
Knights Templar Hosp., Arlington.
Woodward, Valin R., (Inac.),
P. O. Box 1172, Austin.
Worrall, Cyrus L.,
554 S. Summit St., Fort Worth.
Wyss, Herbert E., Keller.
Zimmerman, Ben E.,
1901 N. E. 28th St., Fort Worth.

TAYLOR-JONES

Adams, Clinton E., 1436 N. 4th St., Abilene.
Adamson, William B.,
1434 N. 4th St., Abilene.
Ailts, Bernard H., 4755 Hartford, Abilene.
Anderson, F. Katherine,
1026 N. 21st St., Abilene.
Andrus, Allen G., Pittard Bldg., Anson.
Arrant, Arthur G., 868 Hickory St., Abilene.
Barron, Stanton J.,
1241 N. Mockingbird, Abilene.
Bessire, Milton C., 1325 Hickory St., Abilene.
Bowyer, Mack F., (Pres.),
1101 N. 19th St., Abilene.
Boyd, Virginia H., Box 333, Abilene.
Bray, Willis J., 1325 Hickory St., Abilene.
Bridge, Harry R.,
1229 N. Mockingbird, Abilene.
Burditt, Jesse N., Clinic Bldg., Abilene.
Burditt, Tom C., 1442 N. 3rd St., Abilene.
Burns, Coleman C., 1026 N. 21st St., Abilene.
Buzbee, H. Ray, 1101 N. 19th St., Abilene.
Cadenhead, James P., Haskell.
Cash, W. Auda V., 1101 N. 19th St., Abilene.
Chapel, James P., 1442 N. 3rd St., Abilene.
Clark, J. Frank, 1325 Hickory, Abilene.
Cockerell, Earl R., Clinic Bldg., Abilene.
Colbert, Robert E., Rule Clinic, Rule.
Crow, Jack A., 1825 Hickory, Abilene.
Day, Wm. Kenneth,
1231 N. Mockingbird, Abilene.
Donnell, Ralph E., Jr.,
1133 N. 19th St., Abilene.
Duff, J. C., 1054 12th St., Anson.
Estes, Bobby Jack, 641 Hickory St., Abilene.
Estes, Jack M., 641 Hickory, Abilene.
Estes, Sol B., 1502 N. 2nd St., Abilene.
Evans, Robert W., Clyde.
Fox, W. Irby, 1227 N. Mockingbird, Abilene.
Gardner, Chester B., Merkel.
Gibson, John P., 202 Grape St., Abilene.
Gilmore, John F., 4755 Hartford St., Abilene.
Hamilton, Hinton H.,
4755 Hartford St., Abilene.
Harper, Orville E., 1101 N. 19th St., Abilene.
Hawkins, Elmer J., Hamlin.
Haynes, Jack S., 725 Leggette Dr., Abilene.
Hedrick, T. Wade, 1101 N. 19th St., Abilene.
Helcher, Phyllis O., 1436 N. 4th St., Abilene.
Hollis, Scott W., 1725 Hickory St., Abilene.
Hooks, Jim M., 1133 N. 19th St., Abilene.
Hudson, F. E., (Hon.), Stamford.
Hudson, Isaac F., Stamford.
Jensen, Meredith N.,
1243 N. Mockingbird, Abilene.
Johns, Richard B., 802 Mulberry St., Abilene.
Johnson, Dale F., 4755 Hartford, Abilene.
Johnson, Laurence F., Clinic Bldg., Abilene.
Lynn, Sherwood C., 1026 N. 21st St., Abilene.
Magee, Jefferson D., Jr.,
1101 N. 19th St., Abilene.
McDonald, Donald H., Clinic Bldg., Abilene.
McFadden, C. Alfred,
1325 Hickory St., Abilene.
Merrick, J. Estes, 851 Orange St., Abilene.
Metz, Louis F., Stamford.
Middleton, Edwin E., 1442 N. 3rd St., Abilene.
Morgan, Clyde N., 2073 Cedar, Abilene.
Murtha, Carroll E., 3333 S. 11th St., Abilene.
Nystrom, Robert E., 1442 N. 3rd St., Abilene.
Palasota, Pete C., 254 Leggette Dr., Abilene.
Pate, Virgil A., Jr., 1101 N. 19th St., Abilene.
Pattillo, Guy L., 2073 Cedar St., Abilene.
Perrin, E. Douglas, Hamlin.
Petty, Preston D., 1325 Hickory, Abilene.
Pickard, Luther J., Clinic Bldg., Abilene.
Pittard, Knox J., 1054 12th St., Anson.
Prichard, Clarence L., 2042 S. 8th, Abilene.
Pruet, Royce W., 1325 Hickory, Abilene.
Pryor, George E., Jr., Stamford.
Pugh, David F., 4755 Hartford, Abilene.
Ramsey, Wayne V., 1725 Hickory St., Abilene.
Ramsey, Wayne V., Jr.,
1725 Hickory St., Abilene.
Rode, R. Lee Henry, 1101 N. 19th St., Abilene.
Roe, Maurice A., 2241 S. 19th St., Abilene.
Sadler, William T., Merkel.
Seale, Hubert J., 1325 Hickory, Abilene.
Seale, W. Hubert, 1325 Hickory, Abilene.
Sellers, Earle D., Clinic Bldg., Abilene.
Selmon, Tony B., Stamford.
Shoultz, V. H., 1101 N. 19th St., Abilene.
Sibley, William R., Jr.,
1101 N. 19th St., Abilene.
Smith, Marshall L., Hamlin.
Smith, Travis, 1442 N. 3rd St., Abilene.
Snow, Joseph C., 851 Orange, Abilene.
Steward, Mary Booth,
Box 422, Rt. 1, Maple Valley, Wash.
Strole, Donald G., 1026 N. 21st, Abilene.
Taylor, Floyd D., 4755 Hartford, Abilene.
Thigpen, Joe E., 1417 N. 1st St., Haskell.
Thurman, George D.,
1101 N. 19th St., Abilene.
Tull, Raymond H., 1142 N. 13th St., Abilene.
Tull, Raymond H., Jr., 1301 Cedar St., Abilene.
Turnbull, Marshall D.,
1026 N. 21st St., Abilene.
Varner, Roy W., 1026 N. 21st, Abilene.
Warren, Donald W.,
Sadler Clinic Hosp., Merkel.
Webster, L. J., 1101 N. 19th St., Abilene.
Williams, Charles F., 116½ Chestnut, Abilene.
Williams, Jarrett E., (Sec'y),
1101 N. 19th St., Abilene.
Williams, William H.,
1325 Hickory St., Abilene.
Williamson, Lee, 1101 N. 19th St., Abilene.

WICHITA

Acker, Julian H., 1300 8th St., Wichita Falls.
Adams, Jerome M., 121 Hill Top, Burkburnett.
Adams, Walter B., Jr.,
1100 8th St., Wichita Falls.
Adams, Walter B., Sr.,
1100 8th St., Wichita Falls.
Alexander, Howard G.,
Wichita State Hosp., Wichita Falls.
Allen, David H.,
Medical Arts Bldg., Wichita Falls.
Arrington, John H., 1411 9th St., Wichita Falls
Bailey, Edward B., (Hon.),
1701 Huff St., Wichita Falls.
Bates, Charles R., 1501 5th St., Wichita Falls.
Bates, Harriet H., (Int.),
Wichita Gen. Hosp., Wichita Falls.
Bebb, Edwin C., 5th & Broad, Wichita Falls.
Bebb, Kenneth C., 1518 10th St., Wichita Falls.
Berg, Owen C., 1300 8th St., Wichita Falls.
Bondurant, Drewry C.,
4811 Lake Park Dr., Wichita Falls.
Bradford, Clarence T., (Hon.), Burkburnett.
Brown, Charles H., 1418 8th St., Wichita Falls.
Browne, Frank S., (Sec'y),
Medical Arts Bldg., Wichita Falls.
Buchanan, Martha B., 700 Brook, Wichita Falls.
Burross, D. Clifford,
4007 Faith Road, Wichita Falls.
Carpenter, Philip A., Burkburnett.
Carson, John D., 1518 10th St., Wichita Falls.
Caskey, Marion W.,
311 Hamilton Bldg., Wichita Falls.
Clark, Gordon G., Iowa Park.
Coleman, Blair P., 1300 8th St., Wichita Falls.
Collins, R. Paul, 500 Broad St., Wichita Falls.
Cox, E. Aubrey,
5th & Broad Sts., Wichita Falls.
Crump, William E.,
1300 8th St., Wichita Falls.
Daily, Robert L.,
115 Med. Arts Bldg., Wichita Falls.
Davey, Joseph A., 617 Ave. D., Burkburnett.
Deets, Kenneth H.,
4007 Faith Road, Wichita Falls.
Dorbandt, Barton W.,
1411 9th St., Wichita Falls.
Dryden, Charles B., Jr.,
1511 10th St., Wichita Falls.
Egdorf, Otto C.,
225 Hamilton Bldg., Wichita Falls.
Fish, Pascal E., 419 N. Waggoner St., Electra.
Fletcher, Donald E.,
1600 8th St., Wichita Falls.
Fuller, Colonel B.,
423 Flood St., Wichita Falls.
Hall, Joseph D., 1500 8th St., Wichita Falls.
Hargrave, Robert L.,
218 Hamilton Bldg., Wichita Falls.
Harkins, Thomas A., Box 300, Wichita Falls.
Harrison, William G., Jr.,
1100 8th St., Wichita Falls.
Hathorn, Jerome B., Jr.,
1500 8th St., Wichita Falls.
Heymann, Julius A.,
1518 10th St., Wichita Falls.
Higgs, Robert E., 1511 10th St., Wichita Falls.
Holt, Joseph G., 1518 10th St., Wichita Falls.
Horany, Melvin, Box 858, Archer City.
Huff, Mark E., 2502 10th St., Wichita Falls.
Hulen, William L.,
4007 Faith Rd., Wichita Falls.
Humphrey, Irving L., Jr.,
1300 8th St., Wichita Falls.
Humphrey, T. Roger,
1500 8th St., Wichita Falls.
Irvine, Eleanor S.,
1300 8th St., Wichita Falls.

Irvine, Everett W., Jr.,
1300 8th St., Wichita Falls.
Jackson, John L., III,
1314 9th St., Wichita Falls.
Johnson, James A.,
Hamilton Bldg., Wichita Falls.
Kable, Warren T., Jr.,
1300 8th St., Wichita Falls.
Kanatser, Joseph E.,
1518 10th St., Wichita Falls.
Knight, Ralph W.,
322 Hamilton Bldg., Wichita Falls.
Knox, Roland F., 1300 8th St., Wichita Falls.
Landon, Fred R., (Hon.),
2410 Ellingham Dr., Wichita Falls.
Ledbetter, W. Harry,
1518 10th St., Wichita Falls.
Lee, Frank J., 1300 8th St., Wichita Falls.
Lee, James T., 1300 8th St., Wichita Falls.
Little, James A., Staley Bldg., Wichita Falls.
Lovett, James P., Olney.
Lowry, William P., 1502 8th St., Wichita Falls.
Lynch, Thomas C., (Hon.),
1704 Austin, Wichita Falls.
Manar, Roger W., 1400 8th St., Wichita Falls.
Mansur, Harl D., Jr.,
1400 8th St., Wichita Falls.
Martinez A, Agustin, Box 300, Wichita Falls.
Maxfield, Jack E., 1300 8th St., Wichita Falls.
McCall, J. Preston, 1300 8th St., Wichita Falls.
McFatridge, Keith W.,
1618 10th St., Wichita Falls.
McKinney, James R.,
2012 Taft St., Wichita Falls.
Meredith, E. Filmore, 306 W. Main, Olney.
Moffitt, O. Peyton, 1300 8th St., Wichita Falls.
Munro, L. Alton, 1300 8th St., Wichita Falls.
Nail, James B., 1410 8th St., Wichita Falls.
Nail, James B., Jr., 1410 8th St., Wichita Falls.
Nelson, Richard L., (Pres.),
W. F. Clinic Hosp., Wichita Falls.
Ogden, William H., (Hon.), Electra.
Pace, Robert E., Jr.,
1702 7th St., Wichita Falls.
Parker, William L., 1300 8th St., Wichita Falls.
Parsons, Clyde W., 1300 8th St., Wichita Falls.
Perry, John H., Jr.,
Med. Arts Bldg., Wichita Falls.
Pierce, Alexander W.,
1518 10th St., Wichita Falls.
Powers, Stephen A.,
5th & Broad Sts., Wichita Falls.
Powers, William L.,
1518 10th St., Wichita Falls.
Prichard, Horace D.,
1502 8th St., Wichita Falls.
Reagan, John R., 1511 10th St., Wichita Falls.
Rector, William L.,
1518 10th St., Wichita Falls.
Reser, Wayne A., 1504 8th St., Wichita Falls.
Rodriguez, Juan A.,
1300 8th St., Wichita Falls.
Rosenblatt, William,
1504 8th St., Wichita Falls.
Rosewall, Charles R., (Mil.),
812 Denver St., Wichita Falls.
Scofield, James A., Jr.,
1500 8th St., Wichita Falls.
Seibold, George J.,
702 Brook St., Wichita Falls.
Shaw, Clinton M., Jr.,
1518 10th St., Wichita Falls.
Shepley, Felix R.,
1518 10th St., Wichita Falls.
Simmons, Lillard N.,
1518 10th St., Wichita Falls.
Slaughter, George W., III,
1300 8th St., Wichita Falls.
Smith, Percy K.,
W. F. Clinic Hosp., Wichita Falls.
Speakman, Walter F.,
812 Denver St., Wichita Falls.
Steed, Joe D., 1300 8th St., Wichita Falls.
Sullivan, Harley C.,
500 Broad St., Wichita Falls.
Taylor, Fred W., 1511 10th St., Wichita Falls.
Terry, Houston H., (Hon.),
3205 Montague, Fort Worth.
Theimer, Louis M.,
115 Med. Arts Bldg., Wichita Falls.
Thompson, John G., Electra.
Thornton, Gail, Jr.,
Brook Med. Center, Wichita Falls.
Trimble, Orman H.,
110 Med. Arts Bldg., Wichita Falls.
VanDeventer, Loyd R.,
1702 7th St., Wichita Falls.
Walker, William J.,
P. O. Box 300, Wichita Falls.
Whiting, Walter B.,
1300 8th St., Wichita Falls.
Wilson, Charles H.,
1300 8th St., Wichita Falls.
Wilson, Claude D.,
1300 8th St., Wichita Falls.
Wilson, Oscar W.,
214 Hamilton Bldg., Wichita Falls.
Worthen, John E., Jr.,
2502 10th St., Wichita Falls.
Yeager, Ben G.,
Wichita Falls State Hosp., Wichita Falls.
Yero, Oscar, Box 300, Wichita Falls.

WILBARGER

Borchardt, Alvin L., Vernon.
Coleman, William C., Vernon.
Featherston, Elmer W., (Sec'y),
Med. & Surg. Clinic, Vernon.
Hardin, John B., 1912 Pease St., Vernon.
Hollar, Emory D., Vernon.
Lemee, Raymond A., Vernon.
Miller, Bradford W.,
Herring Natl. Bk. Bldg., Vernon.
Muirhead, James J., Vernon.
Rogers, Albert C., Vernon.
Slaugenhop, James J.,
2805 Wilbarger St., Vernon.
Spaar, Albert P., (Pres.), Vernon.
Steele, Franklin B.,
Herring Bank Bldg., Vernon.

FOURTEENTH DISTRICT

Dr. R. M. Tenery, Waxahachie, Councilor

COLLIN

Apple, George W., 1534 K St., Plano.
Boring, Billy Ray, 1911 Westway, McKinney.
Carabasi, Robert J.,
Vet. Adm. Hosp., McKinney.
Castner, Chas. W.,
Rusk State Hosp., Rusk
Erwin, J. C., Jr., McKinney.
Hooper, John M., McKinney.
Mitchell, Glenn C.,
303 W. Virginia St., McKinney.
Mitchell, Oliver T., Plano.
Pink, Erwin G., (Sec'y), Frisco.
Powell, William J.,
McKinney at Main, Richardson.
Quattlebaum, James E.,
311 N. Tennessee, McKinney.
Searcy, Marshall M., Searcy Clinic, McKinney.
Shumway, Charles M., (Pres.), McKinney.
Stephenson, Martin L., Jr.,
V. A. Hospital, McKinney.
Trimble, Terrill, Wylie Clinic, Wylie.
Truett, Harvey K., McKinney.
Webb, Jack L., Box 192, Farmersville.
Wright, William C., Farmersville.
Wysong, Charley E.,
Wysong Clinic, McKinney.
Wysong, H. Dudley,
Wysong Clinic, McKinney.
Wysong, W. Scott, Jr.,
Wysong Clinic, McKinney.

COOKE

Alston, Herbert M.,
502 East Broadway, Gainesville.
Atchison, James W.,
215 S. Commerce, Gainesville.
Cirone, Vincent C.,
110 East Pecan, Gainesville.
Davenport, Howard S.,
318 E. Elm, Gainesville.
Fisch, Ben R.,
110 East Pecan, Gainesville.
Kaden, Van G., (Sec'y.),
206 Schad and Pulte, Gainesville.
Lively, Gerald A.,
Box 296, Whitesboro.
Lusk, Clu Flu (Pres.),
Box 736, Gainesville.
McLeroy, Robert L.,
528 S. Dixon, Gainesville.
Mills, Charles K., Box 414, Gainesville.
Myrick, Thomas S., Muenster.
Powell, William F., Box 721, Gainesville.
Saikin, Stanley E.,
110 East Pecan, Gainesville.
Shea, John D., Box 532, Gainesville.
Thomas, Ira L.,
215 S. Commerce, Gainesville.
Yarbrough, Silas M., (Hon.),
319½ E. Calif., Gainesville.

DALLAS

Abrams, Raymond H.,
3707 Gaston Avenue, Dallas.
Adams, Reuben H.,
Parkland Mem. Hosp., Dallas.
Addison, Jack J.,
8146 San Benito, Dallas.
Adin, Louis E., Jr., 3707 Gaston, Dallas.
Adwan, Kenneth O., (Int.),
3706 N. Versailles, Dallas.
Aldredge, Geo. N., Jr.,
623 Medical Arts, Dallas.
Alexander, Jo C., 3707 Gaston, Dallas.
Alexander, Lee J.,
Medical Arts Bldg., Dallas.
Alexander, Sam A., 3707 Gaston, Dallas.
Alfieri, Anthony L.,
3427 Cedar Springs, Dallas.
Allday, Louie E., 2929 Welborn, Dallas.
Allen, John B., 4105 Live Oak, Dallas.
Allen, S. Thomas, (Mil.),
808 Delano, San Lorenzo, Calif.
Allison, Joe M., Box 215, Grapevine.
Allman, Robert M., Jr., (Mil.),
U. S. P. H. S. Hosp., Seattle, Wash.
Almand, James R, Jr., (Mil.),
Naval Air Station, Dallas.
Altick, Frank J.,
9528 Lemmon Ave., Dallas.
Altman, William A.,
202 West 10th St., Dallas.
Anderson, T. McDowell,
V. A. Hospital, Coral Gables, Fla.
Andreassian, M. G.,
8215 Westchester, Dallas.
Andrew, William H., Jr.,
V. A. Hospital, Dallas.
Anthony, James M.,
8215 Westchester, Dallas.
Archer, Richard K., (Int.),
10125 Brockbank, Dallas.
Armstrong, J. Otis,
3810 Swiss Ave., Dallas.
Arnold, Lawrence E., 3607 Gaston, Dallas.
Arnspiger, Larry A.,
1511 N. Beckley, Dallas.
Aronoff, Billie L., 3607 Gaston, Dallas.
Aronson, Howard S.,
926 Med. Arts Bldg., Dallas.
Ashby, John E., 3610 Fairmount, Dallas.
Ashe, William M., 919 Medical Arts, Dallas.
Ashworth, Charles T.,
5323 Harry Hines, Dallas.
Aten, Eugene L., 8215 Westchester, Dallas.
Atkinson, Geo. N., Jr.,
101 N. Zangs Blvd., Dallas.
Austin, Dale J., 1008 N. Washington, Dallas.
Austin, Flavius L., Jr., (Int.),
915 St. Joseph, Dallas.
Austin, Frank H., 8215 Westchester, Dallas.
Austin, Ona Mae, 101 S. Iowa, Irving.
Bagwell, John S., 3710 Swiss, Dallas.
Bailey, Herbert A.,
1414 Med. Arts Bldg., Dallas.
Baird, Sydney S., Box 28, Dallas.
Baird, William, D., 1500 N. Marion, Garland.
Baker, B. Orland, Jr., (Int.),
111 East Woodin, Dallas.
Baker, John O., 111 E. Woodin, Dallas.
Baldwin, Alvin, Jr., 3707 Gaston, Dallas.
Baldwin, James L.,
1627 Med. Arts Bldg., Dallas.
Baldwin, Marion C. L., (Int.),
5916 Azalea Ave., Dallas.
Ball, James A., 10801 Garland Rd., Dallas.
Balla, George A., 3707 Gaston Ave., Dallas.
Barekman, Wm. H.,
1221 Med. Arts Bldg., Dallas.
Barkman, Floyd J.,
1603 Junior Drive, Dallas.
Barnes, Bruce S., 3330 S. Lancaster, Dallas.
Barnes, Dorsey K., 3701 Maple, Dallas.
Barnes, Thomas S., 118 S. Edgefield, Dallas.
Barnett, Jack A, (Int.),
Parkland Mem. Hosp., Dallas.
Barnett, William D., (Int.),
Parkland Mem. Hosp., Dallas.
Barnett, William E., 3534 Maple Ave., Dallas.
Barr, W. Tom, Medical Arts Bldg., Dallas.
Barron, Stewart S., (Int.),
3616 Maple, Dallas.
Barton, Robert M., 3601 Swiss Ave., Dallas.
Barzune, Benjamin, 1614 N. Industrial, Dallas.
Bashour, Samuel B.,
2020 W. Grauwyler, Irving.
Baskin, John L., 8215 Westchester, Dallas.
Bass, James W., City Health Dept., Dallas.
Bass, Robert K., (Int.),
3205 Oak Lawn, Dallas.
Bassett, Wallace H., 3707 Gaston, Dallas.

Bates, Richard D., (Int.),
Childrens Med. Center, Dallas.
Bayoud, George S.,
2643 S. Garland Ave., Garland.
Bayoud, Paige B., 9323 Garland Rd., Dallas.
Beall, John R., 2615 Cole Ave., Dallas.
Beaver, Norman B., (Hon.),
P. O. Box 72, San Francisco, Calif.
Beckering, Henry H., 3701 Maple, Dallas.
Bell, Marvin D.,
1109 Med. Arts Bldg., Dallas.
Bell, Wm. Sterling,
5323 Harry Hines, Dallas.
Bennett, Katharine P.,
915 St. Joseph, Dallas.
Bennett, Thomas R., Jr.,
3707 Gaston Ave., Dallas.
Berbary, Maurice S., (Mil.),
Walter Reed Hosp., Washington 12, D.C.
Berger, Benjamin J.,
8215 Westchester, Dallas.
Berk, William R., 1909 Second Ave., Dallas.
Bernhardt, Donald R.,
Medical Arts Bldg., Dallas.
Best, Abraham R., 101 S. Iowa, Irving.
Biggart, James F., Jr., 3607 Gaston, Dallas.
Binion, John T., 3707 Gaston Ave., Dallas.
Bisland, Theodore, 3707 Gaston Ave., Dallas.
Black, J. Harvey, 1405 Medical Arts, Dallas.
Blair, D. Shelton, 1609 Medical Arts, Dallas.
Blanton, Bassel N., 532 Medical Arts, Dallas.
Blend, Max H., 3607 Gaston Ave., Dallas.
Bliss, Sheldon P.,
600 La Veta Dr., N.E., Albuquerque, N. M.
Block, Harold M., Medical Arts Bldg., Dallas.
Block, Richard E., 3707 Gaston Ave., Dallas.
Bloss, Charles L.,
1420 Med. Arts Bldg., Dallas.
Boland, Grant L., 1423 Medical Arts, Dallas.
Bondy, Robert C., Jr., (Int.),
2306 Welborn, Dallas.
Bone, Fred W., 3702 Worth, Dallas.
Bonte, Frederick J.,
5201 Harry Hines Blvd., Dallas.
Bookatz, Allan, 3707 Gaston, Dallas.
Boone, Clifford M., 121 S. Zangs, Dallas.
Booth, James, 3330 S. Lancaster, Dallas.
Bornstein, David M.,
3707 Gaston Ave., Dallas.
Boswell, George M., Jr.,
364 Casa Linda Plaza, Dallas.
Bounds, Murphy, Medical Arts Bldg., Dallas.
Bourland, J. W., Jr., 4105 Live Oak, Dallas.
Bourland, J. W., Sr., (Hon.),
4105 Live Oak, Dallas.
Bourland, John B., Box 28, Dallas.
Bowden, Ben W., 10801 Garland Rd., Dallas.
Boyer, Lorenzo A., 7117 Mil. Parkway, Dallas.
Bracken, Frank L.,
111 N. E. 11th St., Grand Prairie.
Bradfield, James Y., 3601 Swiss Ave., Dallas.
Bradfield, John L.,
Medical Arts Bldg., Dallas.
Bradford, Harry M., (Hon.),
1232 N. Selva Dr., Dallas.
Bradford, William H.,
3714 Fairmount, Dallas.
Bralley, Ernest M., Jr., (Mil.),
20th Sta. Hosp., New York, N. Y.
Branch, George R., 4143 Cole Ave., Dallas.
Branch, William M.,
514 Med. Arts Bldg., Dallas.
Brannin, Dan, 929 Medical Arts, Dallas.
Brau, J. Gilmore, 3817 Brown St., Dallas.
Breihan, E. W., Box 5297, Dallas.
Brereton, Gilbert E.,
723 Medical Arts, Dallas.
Brooking, Donald G. W.,
414 Medical Arts, Dallas.
Brooks, Ernest J., (Hon.),
1312 N. Henry Road, Arlington.
Brooksaler, Fred S., 4207 Lemmon, Dallas.
Brown, C. Frank, P. O. Box 2699, Dallas.
Brown, Donald S., 3710 Swiss, Dallas.
Brown, Harold, 1400 Marion, Garland.
Brown, Olen E., (Hon.),
8903 S. Beckley, Dallas.
Brown, Samuel R.,
219 West 10th St., Dallas.
Browning, Carroll W., 101 N. Zangs, Dallas.
Bruce, Charles H.,
1317 N. Washington, Dallas.
Bruce, R. Grady, 209 Med. Arts Bldg., Dallas.
Brunken, Robert B.,
3707 Gaston Ave., Dallas.
Bruton, Emmett B., 4217 Swiss Ave., Dallas.
Bryan, Nelson A., (Hon.),
978 Peavy Rd., Dallas.
Bryan, Robert T., Jr.,
3511 Fairmount, Dallas.
Buckholts, Walter H.,
V. A. Hospital, Dallas.
Buehler, Martin S., 3225 Turtle Creek, Dallas.
Buell, David S., 8215 Westchester, Dallas.
Buford, Lee Owen S.,
2514 Welborn St., Dallas.
Bullion, Charles F.,
233 W. Wheatland Rd., Dallas.
Bumpass, S. R., 915 St. Joseph, Dallas.
Burford, Raymond W.,
4105 Live Oak, Dallas.
Burke, Leon O., (Int.),
1819 Mariposa Dr., Dallas.
Burkett, Howard M.,
1530 Med. Arts Bldg., Dallas.
Burnett, Jack F., (Mil.), Dallas.
Burns, Maudie Marie,
Medical Arts Bldg., Dallas.
Burnside, Ronald M., 4105 Live Oak, Dallas.
Bush, Oliver F., 3707 Gaston Ave., Dallas.
Bush, W. Leslie, 3707 Gaston Ave., Dallas.
Bussey, C. D., Medical Arts Bldg., Dallas.
Butte, Felix L., Medical Arts Bldg., Dallas.
Byrom, Emmett T., 1603 Medical Arts, Dallas.
Bywaters, T. W., 3607 Gaston, Dallas.
Caillet, O. Rene, 8215 Westchester, Dallas.
Cairns, A. B., 3511 Fairmount, Dallas.
Calhoun, Nina Fay,
1532 Medical Arts, Dallas.
Cameron, Lawrence C.,
4407 Oak Lawn, Dallas.
Camp, Thomas F., Jr., (Int.),
4500 S. Lancaster, Dallas.
Campbell, Allen D., Jr.,
1202 N. Beckley, Dallas.
Campbell, Donovan, (Mil.),
5672 Laredo Rd., Riverside, Calif.
Campbell, Robert D.,
10023 Garland Rd., Dallas.
Campbell, Robert G.,
8215 Westchester, Dallas.
Capps, Robert T., 5201 Harry Hines, Dallas.
Carlson, Glenn D.,
1221 Med. Arts Bldg., Dallas.
Carman, H. Frank,
830 Med. Arts Bldg., Dallas.
Carney, James P.,
936 N. Edgefield Ave., Dallas.
Carpenter, Robert G.,
1203 N. Madison, Dallas.
Carrell, Brandon, 3701 Maple, Dallas.
Carroll, Benjamin H., 2600 Welborn, Dallas.
Carswell, Winston E.,
Med. Arts Bldg., Dallas.
Carter, C. B., Med. Arts Bldg., Dallas.
Carter, David W., Jr.,
3707 Gaston Ave., Dallas.
Carter, Earl L., 528 Med. Arts Bldg., Dallas.
Carter, H. Gray, 915 St. Joseph St., Dallas.
Chandler, H. Norman, 6331 Prospect, Dallas.
Chaney, Clyde E., 9323 Garland Rd., Dallas.
Chapman, Carleton B.,
5323 Harry Hines, Dallas.
Chapman, John S.,
3606 Lovers Lane, Dallas.
Cheek, J. Harold, 3707 Gaston Ave., Dallas.
Cherry, Glenn R.,
909 Med. Arts Bldg., Dallas.
Chester, John B.,
3330 S. Lancaster, Dallas.
Chisolm, Jack T.,
426 Med. Arts Bldg., Dallas.
Christianson, Lynn C.,
3819 Maple Ave., Dallas.
Clariday, John M.,
9528 Webbs Chapel Road, Dallas.
Clark, Arthur L., Med. Arts Bldg., Dallas.
Clark, Fannie M., 3829 Hall St., Dallas.
Clark, Harold G., Med. Arts Bldg., Dallas.
Clark, Helen, 10317 Hedgeway Dr., Dallas.
Clark, William K.,
5323 Harry Hines, Dallas.
Clarkson, Alwin M., 526 E. Jefferson, Dallas.
Claunch, Ben C.,
Vet. Adm. Hosp., Providence, R. I.
Cleveland, Edwin M., 4105 Live Oak, Dallas.
Cobb, Joseph B., 9323 Garland Rd., Dallas.
Cobb, Stephen W.,
317 N. Zangs Blvd., Dallas.
Coggeshall, Howard C.,
3710 Swiss Ave., Dallas.
Cole, Charles Max, (Sec'y),
1421 Med. Arts Bldg., Dallas.
Cole, Gillon M., 1315 Eastus Dr., Dallas.
Colip, William L.,
330 N. W. 2nd St., Grand Prairie.
Collier, Gates, 2901 Hanover, Dallas.
Collier, Richard E.,
Baylor Hospital, Dallas.
Connor, Robert B., 8215 Westchester, Dallas.
Conrad, Emmett J., 4303 Oakland, Dallas.
Conyers, Loyd W.,
208 Med. Arts Bldg., Dallas.
Cook, Chester E.,
Southwestern Life Bldg., Dallas.
Cooper, Jack C., (Int.),
John Hopkins Hosp., Baltimore, Md.
Copeland, Horace V., (Hon.),
125 S.W. Dallas St., Grand Prairie.
Corgill, Donald A.,
Vet. Adm. Hosp., Dallas.
Council, Frank C., Jr., (Int.),
705 Randal Mill Rd., Arlington.
Courtin, Raymond F.,
5928 Swiss Ave., Dallas.
Cox, Eli R., 6331 Prospect, Dallas.
Cox, Kelly, 630 Med. Arts Bldg., Dallas.
Cox, Thomas R., Jr.,
3500 Gaston Ave., Dallas.
Cox, Virgil M., Jr., (Mil.),
4081st USAF Hosp., New York, N. Y.
Crane, Frances B., 936 N. Edgefield, Dallas.
Crane, William D., 936 N. Edgefield, Dallas.
Crawford, Franklin L.,
501 Jefferson St., Cedar Hill.
Crenshaw, Allen, Jr.,
3707 Gaston Ave., Dallas.
Crow, William E.,
1028 Med. Arts Bldg., Dallas.
Crutcher, Howard K.,
1511 N. Beckley, Dallas.
Crutcher, Howard K., Jr., (Mil.),
USA Lexington, FPO, San Francisco, Calif.
Culbertson, Marvin C.,
3619 Fairmount, Dallas.
Culmer, Harold H., 2626 Bryan, Dallas.
Culwell, Jerry H., 642 E. 2nd St., Irving.
Cupp, Charles D.,
1114 E. Main, Grand Prairie.
Curtess, Ross L., Jr.,
3607 Gaston Ave., Dallas.
Cushing, Ivan E., Jr., (Int.),
Parkland Mem. Hosp., Dallas.
Daily, William M.,
3707 Gaston Ave., Dallas.
Daniel, Ruby K., 3116 Live Oak, Dallas.
Darrough, Lawrence E.,
4105 Live Oak, Dallas.
Dathe, Richard A., 3707 Gaston Ave., Dallas.
Daughety, Jewel S., (Mil.),
443 Elmhurst, San Antonio.
Davidson, G. A., 4105 Live Oak, Dallas.
Davidson, Joseph W., Jr.,
302 Preston Royal Med. Center, Dallas.
Davidson, Vanda A.,
3207 Turtle Creek, Dallas.
Davis, Leo G., 521 Med. Arts Bldg., Dallas.
Davis, Milton V., 3707 Gaston Ave., Dallas.
Dawson, J. L., (Hon.),
4533 S. Versailles, Dallas.
Dean, William B., 238 West 10th St., Dallas.
DeGinder, William L.,
Vet. Adm. Hosp., Dallas.
DeHaro, J. Anthony,
2923 Fairmount, Dallas.
DeLange, Arnott, 1511 N Beckley, Dallas.
deLarios, Arthur T., 3631 Fairmount, Dallas.
Denman, John L., 3707 Gaston Ave., Dallas.
Denny, Ben W., 1511 N. Beckley, Dallas.
Denton, Guy T., Jr.,
1311 N. Stemmons, Dallas.
Denton, Guy T., Sr. (Hon.),
1002 N. Edgefield, Dallas.
D'Errico, Albert P., 3707 Gaston, Dallas.
Devereux, Wm. P.,
1311 N. Washington, Dallas.
Dewlett, Hal J. (Mil.),
Val. Forge Army Hosp., Phoenixville, Pa.
Dierolf, Leon W., Jr.,
1511 N. Beckley, Dallas.
Dimmette, James E.,
3607 Gaston Ave., Dallas.
Dixon, Ward G.,
1420 Med. Arts Bldg., Dallas.
Dixon, Warren F.,
311 Preston Royal Med. Center, Dallas.
Dombrowsky, Edward F.,
233 W. 10th St., Dallas.
Donnelly, Allen D.,
813 Bonham, Grand Prairie.
Donoho, Charles P., 3607 Gaston, Dallas.
Dorman, George W., 3524 Fairmount, Dallas.
Douglas, F. Clark,
1414 Medical Arts, Dallas.
Downs, James T., Jr.,
8540 San Fernando, Dallas.
Downs, James T., III, 3707 Gaston, Dallas.
Driggs, Guy K.,
724 Town Creek Dr., Dallas.
Duckett, J. Warner,
1004 N. Washington, Dallas.
Duncan, Charles N., 6003 Victor, Dallas.
Duncan, Horace E., 4500 Lancaster, Dallas.

Dunlap, Elbert, (Hon.),
5339 Nakoma, Dallas.
Dunlap, J. Hudson, 4000 Junius, Dallas.
Dunlap, John E., 3811 Fairmount, Dallas.
Dunn, Fred H. (Mil.),
U. S. Army Hosp., Camp McCoy, Wis.
Dykes, Thomas L.,
1121 W. Jefferson, Dallas.
Edwards, J. Bruce,
3330 S. Lancaster, Dallas.
Edwards, W. L. Jack, 3710 Swiss, Dallas.
Eisenberg, Alex A., 3707 Gaston Ave., Dallas.
Elder, Lindsey T., Jr.,
1511 N. Beckley, Dallas.
Eliasson, Sven G., 5323 Harry Hines, Dallas.
Emmert, John A.,
8215 Westchester, Dallas.
Emmett, George Earl
915 St. Joseph, Dallas.
Engelbach, Albert G.,
Hotel St. George, Brooklyn, N. Y.
Engles, Estelle S. (Int.),
Methodist Hosp., Dallas.
Engles, Robert E. (Int.),
Methodist Hosp., Dallas.
Ensey, James E.,
310 Preston Royal Med. Center, Dallas.
Epstein, Maurice W., (Int.),
4639 McKinney, Dallas.
Ericson, Ruth Ann, 4227 Herschel, Dallas.
Erwin, Karl W., 10517 Allegheney, Dallas.
Estes, Ivan A., 4227 Herschel, Dallas.
Evans, Allan C. (Mil.),
304 Shreveport Rd., Barksdale AFB, La.
Evans, Edward L.,
1038 E. Kessler Pkwy., Dallas.
Evans, Walter G. (Hon.),
4065 Purdue, Dallas.
Fader, David E., 3707 Gaston, Dallas.
Fain, Allen M., Duncanville.
Fain, Guy Burton (Hon.), DeSoto.
Falke, Clarence G.,
Wynnewood Prof. Bldg., Dallas.
Fangman, Donald F.,
110G Walnut Hill, Dallas.
Fashena, Gladys J.,
Southwest Med. School, Dallas.
Feldman, Jerald (Mil.),
Parkland Mem. Hosp., Dallas.
Ferguson, Doyle W., 3631 Fairmount, Dallas.
Fiegel, Walter L., Box 576, Carrollton.
Fine, Jacob S., 3614 Fairmount, Dallas.
Fink, Frederick, 5806 Joyce Way, Dallas.
Finley, Dorothy G.,
156 Wynnewood Prof. Bldg., Dallas.
Finnegan, Chas. R.,
610 Med. Arts Bldg., Dallas.
Fischer, J. Philip, 3601 Swiss Ave., Dallas.
Fish, Stewart A., 4224 Swiss Ave., Dallas.
Fisher, John W.,
1414 Med. Arts Bldg., Dallas.
Fisher, Thomas B. (Hon.),
5834 Belmont, Dallas.
Flohr, Leonard J.,
Medical Arts Bldg., Dallas.
Flowers, W. K., Jr.,
2317½ Hall St., Dallas.
Fogelman, Morris J.,
3607 Gaston Ave., Dallas.
Fogleman, James D.,
535 W. Pleasant Run Rd., Lancaster.
Foree, Kenneth, III.
631 Med. Arts Bldg., Dallas.
Foster, Fred M. (Mil.),
6316 Lake Shore Dr., Dallas.
Fowler, Hanes M.,
Wynnewood Prof. Bldg., Dallas.
Fox, Everett C.,
Medical Arts Bldg., Dallas.
Franklin, Floyd S., 3606 Maple, Dallas.
Franklin, Robert, Box 66, Carrollton.
Fromm, Chas. S., 3707 Gaston, Dallas.
Fry, Murdock D.,
1132 Med. Arts Bldg., Dallas.
Fuller, William W., 6200 Lemmon, Dallas.
Funk, Presley C., 9528 Lemmon Ave., Dallas.
Fuqua, Foster, 3707 Gaston, Dallas.
Fuqua, W. N., Jr., 3707 Gaston, Dallas.
Gaines, Sidney W.,
134 E. Church, Grand Prairie.
Galt, Jabez, 510 Med. Arts Bldg., Dallas.
Galt, Sidney, 220 Med. Arts Bldg., Dallas.
Garner, Amos D., 3707 Gaston Ave., Dallas.
Garvey, Ronald F. (Int.),
Parkland Mem. Hosp., Dallas.
Geary, Francis B., Jr.,
219 S. Willomet, Dallas.
Geibel, John Wm., Jr.,
4105 Live Oak, Dallas.
Geist, Frederick S.,
Wynnewood Prof. Bldg., Dallas.
Gerard, Marvin (Int.),
Parkland Mem. Hosp., Dallas.
German, James L. (Mil.),
Natl. Ins. of Health, Bethesda, Md.
Gibbons, O. D., Medical Arts Bldg., Dallas.
Gibbons, Raymond R. (Mil.),
James Connally AFB, Waco.
Gibbons, William E.,
Medical Arts Bldg., Dallas.
Gilbert, Franklin M., 101 S. Iowa, Irving.
Gilbert, Stanley L.,
9528 Lemmon Ave., Dallas.
Gilbert, Taylor C.,
1316 Med. Arts Bldg., Dallas.
Giles, Robert B.,
1114 Med. Arts Bldg., Dallas.
Giles, Robert B., Jr.,
Southwest Medical School, Dallas.
Gill, Atticus J.,
7103 Lakewood Blvd., Dallas.
Gill, Dan C., 3707 Gaston, Dallas.
Gilmore, Jack T., 2615 Welborn, Dallas.
Girard, Percy M., 2601 Welborn, Dallas.
Gleichert, James E., 1511 N. Beckley, Dallas.
Glenn, Thomas Lane (Mil.),
MacDill AFB, Tampa, Fla.
Godfrey, William A., Jr. (Mil.),
Carswell AFB Hosp., Fort Worth.
Goff, Gomer F., 3601 Cedar Springs, Dallas.
Goforth, John L., Box 1074, Dallas.
Gomez, Frank, Box 348, Evant.
Goode, James E., 936 N. Edgefield, Dallas.
Goode, John V., 3707 Gaston Ave., Dallas.
Goodfried, Max Paul, 3814 Swiss, Dallas.
Goodlad, James K., 3330 S. Lancaster, Dallas.
Goodson, James H.,
10801 Garland Rd., Dallas.
Gordon, Joseph B., 3707 Gaston Ave., Dallas.
Gorman, James A., Jr. (Int.),
5201 Harry Hines, Dallas.
Gossard, Wayne H., 135 Melba, Dallas.
Goth, Andres, 5323 Harry Hines, Dallas.
Gottlich, Arthur P.,
800 N. Washington, Dallas.
Grace, Robert W., 6331 Prospect, Dallas.
Gracia, Valentin (Int.),
Baylor Hospital, Dallas.
Grafton, Edwin G., 8215 Westchester, Dallas.
Graham, James F., 1418 W. Jefferson, Dallas.
Graham, Marion F.,
9323 Garland Rd., Dallas.
Graham, Russell B., 4105 Live Oak, Dallas.
Grater, William C.,
1620 Med. Arts Bldg., Dallas.
Gray, George A., 3700 Ross Ave., Dallas.
Green, Adam D., 4105 Live Oak, Dallas.
Green, F. Ray, 8327 Santa Clara, Dallas.
Green, Tim R., 1107 W. Jefferson, Dallas.
Green, William, 3205½ Thomas Ave., Dallas.
Green, Willie Joe, 5535 Denton Dr., Dallas.
Gregory, Charles F.,
5323 Harry Hines, Dallas.
Greve, Marion J., 3710 Swiss, Dallas.
Griffin, Jack B., 800 N. Washington, Dallas.
Griffith, E. Clay (Int.),
P. O. Box 1769, Dallas.
Grollman, Arthur 5323 Harry Hines, Dallas.
Gross, Perry E., 3707 Gaston Ave., Dallas.
Grossman, Mervin H.,
St. Paul Hospital, Dallas.
Grow, Max H., 3616 Maple Ave., Dallas.
Guerriero, Wm. F.,
3207 Turtle Creek, Dallas.
Hackney, U. P., Medical Arts Bldg., Dallas.
Hale, Martha Helen, 3403 Hall, Dallas.
Halebian, Hratch S., (Mil.),
2nd Gen. Hosp., APO 180, New York, N. Y.
Haley, Arvel E., 201 West 10th St., Dallas.
Haley, William E.,
702 Med. Arts Bldg., Dallas.
Hall, John E., 3811 Oakland Ave., Dallas.
Hall, William L., 936 N. Edgefield, Dallas.
Halley, B. C., Jr., 3707 Gaston, Dallas.
Halpern, Salmon R., 3534 Maple, Dallas.
Hamilton, Chas. F.,
1616 Med. Arts Bldg., Dallas.
Hampton, James A.,
1032 Med. Arts Bldg., Dallas.
Hancock, Warren E.,
9323 Garland Rd., Dallas.
Harber, Harry P., 4416 Hall St., Dallas.
Hardy, Douglas M., 3330 S. Lancaster, Dallas.
Hare, Henry P., Jr.,
210 N. Westmoreland, Dallas.
Harper, Jack C., 526 E. Jefferson, Dallas.
Harrel, Don G., 220 W. Oakenwald, Dallas.
Harrell, Ronald R.,
108 N. E. 7th St., Grand Prairie.
Harrington, Francis T.,
9962 Rock Brook Lane, Dallas.
Harrington, Marion Ray,
8215 Westchester, Dallas.
Harrington, S. F.,
8215 Westchester, Dallas.
Harris, Alfred W., 3710 Swiss, Dallas.
Harris, Calvin W., 219 West 10th St., Dallas.
Harris, N. Joe, 8215 Westchester, Dallas.
Harris, William S., 3616 Maple, Dallas.
Harris, Worth W., 400 S. Ebrite, Mesquite.
Harrison, Ben F., Jr.,
3707 Gaston, Dallas.
Harrison, Frank,
Southwest Medical School, Dallas.
Harrison, Gaston G., 6115 La Vista, Dallas.
Hart, Gaylord A., Medical Arts Bldg., Dallas.
Hartin, Richard B., 808 Avenue A, Garland.
Hartman, James M., 819 Avenue A., Garland.
Harvill, T. Haynes,
1616 Med. Arts Bldg., Dallas.
Hawkins, Hubert F., 3607 Gaston, Dallas.
Hawkins, Wm. C., 4143 Cole Ave., Dallas.
Hayes, Elmer R., 3707 Gaston, Dallas.
Hayes, Horace T.,
289 Casa Linda Plaza, Dallas.
Haynes, William M.,
Wynnewood M. & P. Bldg., Dallas.
Healy, Michael J., 8215 Westchester, Dallas.
Hearn, J. William, (Int.),
3434 Binkley Ave., Dallas.
Hellman, Wayne L. (Int.),
Parkland Mem. Hosp., Dallas.
Henderson, Hodgie C., Jr.,
220 W. Oakenwald, Dallas.
Hendler, Albert F.,
9323 Garland Road, Dallas.
Henry, Albert C., Jr.,
3707 Gaston Ave., Dallas.
Henry, David J., 3607 Gaston Ave., Dallas.
Henry, James W.,
2539 S. Garland Rd., Garland.
Henry, Joseph M.,
205 Marshall Lane Shopping Village, Dallas.
Herndon, Ernest T.,
8215 Westchester, Dallas.
Herndon, James H.,
510 Med. Arts Bldg., Dallas.
Herrick, Richard B.,
531 Med. Arts Bldg., Dallas.
Hershey, Edythe P.,
1114 Commerce St., Dallas.
Hesser, Robert N., 3614 Fairmount, Dallas.
Heyer, Howard E., 3601 Swiss Ave., Dallas.
Hibbitts, William M.,
1631 Med. Arts Bldg., Dallas.
Hill, James R. (Int.),
St. Paul's Hosp., Dallas.
Hill, Joseph M., 6752 Avalon, Dallas.
Hill, S. M., Medical Arts Bldg., Dallas.
Hitt, Rankin V., Jr., (Mil.),
4025 Amherst, Dallas.
Hodges, Harold C., 1508 S. Buckner, Dallas.
Hodges, Leon, 4407 Oak Lawn, Dallas.
Hodges, T. Wiley, 9323 Garland Rd., Dallas.
Hoefer, Carl A. (Inac.),
6720 Braeburn, Dallas.
Hoekstra, Clarence S.,
8215 Westchester, Dallas.
Hoffman, Glenden A.,
Medical Arts Bldg., Dallas.
Hoffman, Mary S., 7431 Midbury Dr., Dallas.
Holland, John, III.
4224 Swiss Ave., Dallas.
Holman, James,
Medical Arts Bldg., Dallas.
Holt, C. Zeno,
10757-A Preston Rd., Dallas.
Holt, J. O. S., Jr., 3707 Gaston Ave., Dallas.
Hood, Marianna, 3707 Gaston, Dallas.
Hopkins, May Agness,
1032 Med. Arts Bldg., Dallas.
Horgan, John D.,
134 E. Church, Grand Prairie.
Horn, Fred W., 5535 Denton Dr., Dallas.
Horn, J. Morris, 3707 Gaston, Dallas.
Howard, Ben K.,
2339 Gus Thomasson Rd., Dallas.
Howard, Charles H., Jr.,
306 Tyler St., Richardson.
Howard, George W., 628 Haines, Dallas.
Howell, Benjamin E.,
3016½ Thomas Ave., Dallas.
Howell, James B.,
Medical Arts Bldg., Dallas.
Hubbard, David G.,
3525 Turtle Creek, Dallas.
Hudson, W. Lee (Hon.),
4312 Overhill Dr., Dallas.
Huggins, Clifford S., V. A. Hosp., Dallas.
Hunsinger, J. Edward,
3988 Central Exp., Dallas.
Hunt, Samuel Lee,
10023 Garland Rd., Dallas.
Hunter, Richard B., 7229 Lehigh, Dallas.
Hurt, Leonard B., 3917 Miramar, Dallas.

Hutcheson, James B.,
3500 Gaston Ave., Dallas.
Hutton, Sam B., Jr., 3707 Gaston, Dallas.
Iliya, Adil, 1011 Shadyside Lane, Dallas.
Irving, W. M. Jr., 820 Irving Blvd., Irving.
Jackson, Claude L., Box 1769, Dallas.
Jackson, Jimmy D., 5511 Hudson, Dallas.
Jackson, Mary Ruth,
3629 Fairmount, Dallas.
Jackson, Michael C., 6315 Prospect, Dallas.
Jacobson, Coleman, 3707 Gaston, Dallas.
James, George Taylor,
3631 Fairmount, Dallas.
James, George Truett, 3701 Maple, Dallas.
James, John A.,
Southwest Medical School, Dallas.
Jenkins, John L.,
722 Med. Arts Bldg., Dallas.
Jenkins, Marion T., Parkland Hospital, Dallas.
Jenkins, Speight,
814 Med. Arts Bldg., Dallas.
Jennings, Mary A., 4210 Lemmon, Dallas.
Jerome, Johnnie Jeff (Mil.),
126 Lakeridge Dr., Dallas.
Johnson, Alvis F., Jr.,
2306 Welborn, Dallas.
Johnson, William B., 6331 Prospect, Dallas.
Johnston, Louis C.,
10th Floor Med. Arts, Dallas.
Jones, George M., 3601 Swiss Ave., Dallas.
Jones, Homer C., Jr.,
2317 Mountain Rd., Dallas.
Jones, J. Guy, 2512 Welborn, Dallas.
Jones, Lawrence R. (Int.),
2039 W. Coil St., Indianapolis, Ind.
Jones, Robert A., Box 398, Lancaster.
Jones, William D., 3116 Live Oak, Dallas.
Jordan, Frank H., 2918 Thomas Ave., Dallas.
Jordan, Fred H.,
210 N. Westmoreland, Dallas.
Jordan, J. Russell, 3607 Gaston, Dallas.
Jordan, Lois F., 3607 Gaston, Dallas.
Kahler, E. Clayton,
Medical Arts Bldg., Dallas.
Kahn, Samuel H.,
Medical Arts Bldg., Dallas.
Kakaska, George H.,
2660 S. Garland Rd., Garland.
Kamholz, Jack H., 3534 Maple, Dallas.
Kantor, Herman I., 3534 Maple, Dallas.
Kaplan, Norman M., (Int.),
Parkland Hospital, Dallas.
Katz, Sol M., 800 N. Washington, Dallas.
Kee, John Lester, Jr.,
3810 Swiss Ave., Dallas.
Keene, Albert H., 3707 Gaston, Dallas.
Keglovits, Michael J.,
2024 W. Grauwyler, Irving.
Keilson, Gerald R. (Mil.),
6208 USAF Hosp., San Francisco, Cal.
Kelley, Charles W., 2900 Gaston Ave., Dallas.
Kelly, Thomas E., 3520 Greenville, Dallas.
Kent, James M., 9323 Garland Rd., Dallas.
Kerr, Jack G., 1610 Med. Arts Bldg., Dallas.
Kidd, Frank H., Jr., 4000 Junius St., Dallas.
Kilgore, Donald G., Sr.,
3988 N. Expressway, Dallas.
Kimsey, Larry R.,
530 N. W. 2nd, Grand Prairie.
Kindley, George C.,
3116 Live Oak, Dallas.
King, Carey G., Jr.,
3707 Gaston Ave., Dallas.
King, Karl B., 3707 Gaston, Dallas.
King, Virgil M.,
220 Med. Arts Bldg., Dallas.
Kipp, Dean C., 3601 Swiss, Dallas.
Kirby, Vernon V., Jr., (Int.),
201 W. Pecan, Celina.
Kirksey, Thomas M.,
Medical Arts Bldg., Dallas.
Kleinsasser, Leroy J., 3707 Gaston, Dallas.
Knapp, Joseph L.,
210 N. Westmoreland, Dallas.
Knickerbocker, Bruce A.
3403 Hall St., Dallas.
Knight, Marvin P., 2618 Welborn, Dallas.
Knowles, W. Mood, 8215 Westchester, Dallas.
Koch, William T., 6331 Prospect, Dallas.
Kohler, Hugh F., 9323 Garland Rd., Dallas.
Krafft, C. James, 3403 Hall, Dallas.
Krakusin, Jacob S.,
109 Walnut Hill Village, Dallas.
Krause, Robert B., (Int.),
3217 Cornell, Dallas.
Krebs, David E.,
525 W. Pleasant Run Rd., Lancaster.
Kregel, Louis A., 3707 Gaston Ave., Dallas.
Krempin, Herman O.,
1511 N. Beckley, Dallas.
Kresh, Herbert, 9105 Diceman Dr., Dallas.
Kreymer, George C.,
1322 Med. Arts Bldg., Dallas.
Krusen, Edward M., Jr.,
Baylor Hospital, Dallas.
Krusen, Ursula M. L.,
3500 Coalgate Ave., Dallas.
Kugler, Joseph S., 109 S. Delaware, Irving.
Kurilecz, Michael,
635 Med. Arts Bldg., Dallas.
Kurilecz, Peter, Jr., (Int.),
Baylor Hospital, Dallas.
Lair, Nard,
231 Lake Park Shopping Village, Dallas.
Laird, Paul C., 122 S. Jefferson, Irving.
Lancaster, Mary Agnes,
1434 Med. Arts Bldg., Dallas.
Landress, J. Byron, 203 S. 8th, Garland.
Langston, William G., 3707 Gaston, Dallas.
Lanier, Jack E., 9528 Lemmon Ave., Dallas.
Lanius, John W.,
220 Med. Arts Bldg., Dallas.
Lankford, Livius L.,
4105 Live Oak, Dallas.
LaPrade, William H.,
9323 Garland Rd., Dallas.
LaRue, Kenneth W., 1001 St. Joseph, Dallas.
Laugenour, Dudley P., 4338 Lemmon, Dallas.
Launey, George V., 4536 S. Lindhurst, Dallas.
Lee, Dorothy (Int.),
St. Paul's Hospital, Dallas.
Lee, Richard H., 6331 Prospect, Dallas.
Lee, Ridings E., 3606 Maple Ave., Dallas.
Legg, Eugene P., 3707 Gaston, Dallas.
Leggett, L. Waldo, Cliff Towers Hotel, Dallas.
Lehman, Irwin (Mil.), Box 883, O'Donnell.
Leland, Glen V., Jr.,
110G Walnut Hill Village, Dallas.
LeMay, Sonley R., Jr., (Int.),
4605 W. Lovers Lane, Dallas.
Lemmon, Mark L.,
1122 Med. Arts Bldg., Dallas.
Leon, Robert L., 5323 Harry Hines, Dallas.
Lester, Roy T., 2208 Main St., Dallas.
Levin, Paul M.,
Medical Arts Bldg., Dallas.
Levy, Harry R., Medical Arts Bldg., Dallas.
Lewis, Elbert H.,
Wynnewood Prof. Bldg., Dallas.
Lewis, Jerry M.,
1420 Med. Arts Bldg., Dallas.
Lewis, Theodore C., Jr. (Mil.),
Box B, Seagoville.
Lieberman, Zelig H.,
3607 Gaston Ave., Dallas.
Liebes, George J., Jr.,
8215 Westchester, Dallas.
Light, Flominda, 7306 Ferguson, Dallas.
Liles, John H., Jr., 3411 Fairmount, Dallas.
Lindsay, Guion A.,
910 Med. Arts Bldg., Dallas.
Lindsay, Joseph H.,
10757-A Preston Rd., Dallas.
Linsey, Ralph M.,
Rockwall Med. Hosp., Rockwall.
Lippas, John, 1717 Pacific, Dallas.
Livingston, Shields O.,
3814 Swiss Ave., Dallas.
Llewellyn, Thomas H. (Int.),
315 Haight St., Menlo Park, Calif.
LoBello, Leon C., 3601 Swiss Ave., Dallas.
Lodowski, Charles H.,
2317 Mt. Lake Road, Dallas.
Loeb, Ellen, 3416 Potomac, Dallas.
Loftis, Earl L., 3707 Gaston, Dallas.
Loftis, J. Stewart (Mil.),
3513 Bryn Mawr, Dallas.
Loiselle, Albert O.,
2601 Welborn, Dallas.
Long, Gerald D., 4338 Lemmon, Dallas.
Long, Troy F., 1510 Med. Arts Bldg., Dallas.
Looney, W. W., 738 West 10th St., Dallas.
Love, Horace G., Jr. (Mil.),
U. S. Naval Hosp., Portsmouth, Va.
Lovell, Barney K., 4500 Lancaster Rd., Dallas.
Lowry, James S., 3601 Swiss, Dallas.
Lu, Jen Lung, 201 West Tenth, Dallas.
Ludden, Keene F., 111 E. Woodin, Dallas.
Luecke, P. E., Sr., Box 28, Dallas.
Luhn, Nellie R., Parkland Hospital, Dallas.
Lukeman, Hermann J.,
9323 Garland Road, Dallas.
Lumpkin, Forrest E., Jr.,
8215 Westchester, Dallas.
Lumpkin, Walter L. (Mil.), Dallas.
Lyday, Victor I., 416 Med. Arts Bldg., Dallas.
Lyon, Edward G. (Hon.),
6909 Junius, Dallas.
MacDonald, Paul C. (Int.),
Parkland Mem. Hosp., Dallas.
Machado C, Gaston, (Int.),
5802 Woodrow Ave., Austin.
Machen, Robert N.,
Wynnewood Prof. Bldg., Dallas.
Madison, Leonard L., 2211 Oak Lawn, Dallas.
Maffett, Minnie L.,
706 Med. Arts Bldg., Dallas.
Magers, Morris E., 4105 Live Oak, Dallas.
Mahaney, Charles L. (Int.),
3121 Bryan, Dallas.
Mahon, George D., Rt 2, Box 304, Garland.
Mahon, Ralph D., Jr., 6003 Victor, Dallas.
Mallams, John T., Baylor Hospital, Dallas.
Maniotis, James G., 1815 West 10th, Dallas.
Marchman, Oscar M., Jr.,
1314 Med. Arts Bldg., Dallas.
Marchman, Oscar M., Sr. (Emer.),
5328 Live Oak, Dallas.
MarDock, Julian, 3418 S. Beckley, Dallas.
Marshall, James H. (Hon.),
6006 Stefani, Dallas.
Martin, Charles L.,
3501 Gaston Ave., Dallas.
Martin, James A., 3501 Gaston, Dallas.
Martin, John G., 1511 N. Beckley, Dallas.
Martin, John T., 3607 Gaston Ave., Dallas.
Martin, Thomas A., Jr.,
832 Med. Arts Bldg., Dallas.
Martinak, Richard E.,
800 N. Washington, Dallas.
Martinez, Daniel M., 1511 N. Beckley, Dallas.
Mason, Eugene E., 3707 Gaston Ave., Dallas.
Mason, Porter K., Med. Arts Bldg., Dallas.
Massad, Eugene M., 13776 Heartside, Dallas.
Mathews, Paul W. (Hon.),
5951 Sherry Lane, Dallas.
Mattson, Harold A., 630 N. Bishop, Dallas.
Mauk, Ferald D.,
Box 6210, Term. Annex, Dallas.
Maxfield, Geo. S., Medical Arts Bldg., Dallas.
Maxfield, James R., Jr.,
311 Med. Arts Bldg., Dallas.
Maxfield, James R., Sr., (Dead).
Maxfield, William S., (Mil.),
U. S. N. Hospital, Bethesda, Md.
Maxwell, Hal W.,
624 Med. Arts Bldg., Dallas.
May, James L., 212 S. Main, Irving.
May, James S., Jr., 3113 Routh St., Dallas.
Mayfield, Imogene, 121 S. Zangs, Dallas.
McAnally, Billie H.,
2341 Gus Thomasson Rd., Dallas.
McBride, Dayton C., 3205 Oak Lawn, Dallas.
McBride, Robert B., 3205 Oak Lawn, Dallas.
McCall, Robert A.,
410 Med. Arts Bldg., Dallas.
McCarley, Ben P., 203 W. Tyler, Richardson.
McCarville, John R.,
3907 Cole, Apt. A, Dallas.
McCauley, H. Leake, Jr.,
1028 W. Boyd, Norman, Okla.
McClung, Hugh L.,
1526 Med. Arts Bldg., Dallas.
McCrory, Thomas M., 3707 Gaston, Dallas.
McCullough, John H.,
182 Casa Linda Plaza, Dallas.
McDonald, Viola Y.,
1449 San Rafael Dr., Dallas.
McFarland, Gordon B.,
3701 Fairmount, Dallas.
McGinnis, Albert, (Int.),
St. Paul's Hosp., Dallas.
McGregor, Robert A.,
710 Med. Arts Bldg., Dallas.
McGuire, Donald E., Jr.,
4227 Herschel, Dallas.
McGuire, Joseph H.,
1110 Med. Arts Bldg., Dallas.
McIver, Julius, 4029 Lemmon, Dallas.
McKinney, James M.,
8215 Westchester, Dallas.
McLaurin, Hugh L. (Hon.),
5036 Seneca Dr., Dallas.
McLeod, James N., (Dead).
McNamara, James C., Jr.,
5221 Locksley, Dallas.
McNeill, Arch J.,
Medical Arts Bldg., Dallas.
McNeill, Joseph P., 3707 Gaston, Dallas.
McPherson, Vernon L., (Dead).
Meadows, Charles T., (Int.),
Parkland Mem. Hosp., Dallas.
Meisenbach, Albert E., Jr.,
317 Med. Arts Bldg., Dallas.
Mendel, E. B., 3702 Worth St., Dallas.
Mendenhall, Elliott,
1217 Med. Arts Bldg., Dallas.
Meredith, C. Spencer, III,
V. A. Hospital, Biloxi, Miss.
Merrick, Ben A.,
3520 Cedar Springs, Dallas.
Metz, M. Hill, 4319 Oak Lawn, Dallas.
Mewhinney, Logan U.,
6115 LaVista, Dallas.

Michael, Ludwig A.,
3707 Gaston Ave., Dallas.
Miller, Alan N., II,
2028 W. Grauwyler, Irving.
Miller, Donald B., Keene.
Miller, Ed Crow,
8215 Westchester, Dallas.
Miller, Ervin Ray,
3330 S. Lancaster, Dallas.
Miller, J. E., 6407 Forest Lane, Dallas.
Miller, John F., 1511 N. Beckley, Dallas.
Miller, Tate, Medical Arts Bldg., Dallas.
Miller, William F.,
Southwestern Medical School, Dallas.
Mills, E. Grady,
2353 Gus Thomasson Rd., Dallas.
Mills, James T., 3707 Gaston, Dallas.
Millwee, Robert H.,
1400 Stemmons Ave., Dallas.
Mims, Harold M., 3607 Gaston Ave., Dallas.
Minnett, John S., 2929 Welborn, Dallas.
Mitchel, Ben F., 3707 Gaston Ave., Dallas.
Mitchell, Harry J., 915 St. Joseph, Dallas.
Mitchell, Joseph D., Jr.,
3707 Gaston, Dallas.
Mitz, Robert,
117 N. E. 8th St., Grand Prairie.
Mobley, Henry Brown (Mil.),
28 Gen. Hosp., APO 219, New York, N. Y.
Montgomery, Henry G., Box 28, Dallas.
Montgomery, John C., 911 St. Joseph, Dallas.
Montgomery, Philip O'B.,
9039 Devonshire Dr., Dallas.
Moody, Joe V., 1511 N. Beckley, Dallas.
Mooney, Ken,
1528 Med. Arts Bldg., Dallas.
Moore, Halcuit, 4105 Live Oak, Dallas.
Moore, Kendall H.,
9323 Garland Rd., Dallas.
Moore, Ramsay H.,
8215 Westchester, Dallas.
Moore, Robert L., 3403 Hall St., Dallas.
Morgan, Bill C. (Int.),
6003 Victor, Dallas.
Morris, A. Truett, 4224 Swiss Ave., Dallas.
Morris, Charles R., 8215 Westchester, Dallas.
Morris, Donald P., 911 St. Joseph, Dallas.
Morrison, Donald D. (Int.),
Parkland Mem. Hosp., Dallas.
Mueller, Helmut A.,
813 N. Zangs Blvd., Dallas.
Muirhead, Ernest E.,
5323 Harry Hines, Dallas.
Mullikin, Gerald G.,
915 St. Joseph St., Dallas.
Munsell, Donald W., 3607 Gaston, Dallas.
Murillo, Sergio L., 3116 Fairmount, Dallas.
Murley, Warren T., Jr., (Int.),
Methodist Hospital, Dallas.
Murphy, Joseph B., 4104 Hanover, Dallas.
Murphy, Joseph G. (Int.),
706 S. Winnetka, Dallas.
Murphy, Thomas P., Jr.,
2024 W. Grauwyler, Irving.
Murray, Hugh D., 317 N. Zangs, Dallas.
Mustain, Rhoads, 3607 Gaston Ave., Dallas.
Nabors, G. Cooley,
Walnut Hill Village, Dallas.
Nash, Gloria H., 1100 N. Canterbury, Dallas.
Nash, Tom M., 729 Med. Arts Bldg., Dallas.
Neal, Leroy J. (Mil.),
P. O. Box 5961, Dallas.
Needham, Perry Q.,
Medical Arts Bldg., Dallas.
Neel, Joseph C., Medical Arts Bldg., Dallas.
Nelson, Arthur G.,
9323 Garland Rd., Dallas.
Nelson, Marion H., 6803 Hillcrest, Dallas.
Nesbit, Harold T., 3707 Gaston Ave., Dallas.
Nesbitt, Irene T., 4335 Lemmon, Dallas.
Neumaier, Hilde, (Int.),
7127-C Village Way, Houston.
Neuman, Albert, 3829 Hall, Dallas.
Newell, Edward A., 1511 N. Beckley, Dallas.
Newell, Philip D., 930 N. Edgefield, Dallas.
Newsom, Asa A., 3707 Gaston, Dallas.
Newsom, Asa A., Jr.,
3707 Gaston Ave., Dallas.
Newton, Frank H.,
209 Med. Arts Bldg., Dallas.
Niblo, Grady, Jr., 351 W. Jefferson, Dallas.
Nicolaou, George T., 911 St. Joseph, Dallas.
Nitsche, Ernest W., 5749 Gaston, Dallas.
Noonan, Richard L.,
111 N. E. 11th St., Grand Prairie.
Norman, Floyd A., 4143 Cole Ave., Dallas.
Nunnelley, Emmett C., Jr.,
3219 Turtle Creek, Dallas.
O'Banion, John Wm., Jr., (Int.),
Parkland Mem. Hosp., Dallas.
Obenchain, Thos. H., Jr.,
3606 Maple Ave., Dallas.
Oberlin, Donald L. (Int.),
St. Paul's Hosp., Dallas.
O'Brien, Harold A., 3707 Gaston, Dallas.
O'Brien, Justin D.,
1135 Med. Arts Bldg., Dallas.
Ogle, Joseph C., 936 N. Edgefield, Dallas.
Oliver, Billy Byrd,
3707 Gaston Ave., Dallas.
Ormond, Anthony Milton (Mil.), Dallas.
Ossenfort, William F.,
5851 Del Roy Dr., Dallas.
Overton, Philip M. (Mil.),
44th Army Hosp., San Francisco, Cal.
Pace, John M., 428 Med. Arts Bldg., Dallas.
Park, Barton E., 1121 W. Jefferson, Dallas.
Parker, Edward R., 5511 Hudson, Dallas.
Parnell, Billy Joe,
1221 Med. Arts Bldg., Dallas.
Passamonte, Jane A.,
1516 W. Jefferson, Dallas.
Paternostro, Chas. J.,
Medical Arts Bldg., Dallas.
Patterson, Casey E.,
729 Med. Arts Bldg., Dallas.
Patterson, Cecil O.,
1414 Med. Arts Bldg., Dallas.
Patton, Walter H., 6003 Victor, Dallas.
Paulson, Donald L., 3810 Swiss Ave., Dallas.
Pauly, A. Nottingham,
936 N. Edgefield, Dallas.
Payne, Frank C., Jr. (Mil.),
Army Surg. Gen. Bldg.,
Washington, D. C.
Payne, Virgil M., Jr.,
1209 Med. Arts Bldg., Dallas.
Pearcy, Frank, 2606 Oak Lawn, Dallas.
Pearson, Huston,
Wynnewood Prof. Bldg., Dallas.
Peden, James K.,
1420 Med. Arts Bldg., Dallas.
Pence, Ludlow M.,
210 N. Westmoreland, Dallas.
Perrin, Robert W., (Int.),
4500 Lancaster St., Dallas.
Peyton, John B.,
Medical Arts Bldg., Dallas.
Pharo, Milam B., 8215 Westchester, Dallas.
Phillips, Franklin M.,
Lederle Lab. Div., Pearl River, N. Y.
Phillips, James R.,
117 N. E. 8th St., Grand Prairie.
Phillips, Roycerene H.,
117 N. E. 8th St., Grand Prairie.
Phillips, Sam H., Jr.,
10023 Garland Rd., Dallas.
Pickard, James M., Courthouse, Dallas.
Pickett, Taylor T., 5702 Goliad, Dallas.
Pickett, William H.,
922 Med. Arts Bldg., Dallas.
Pickle, Coy R.,
1316 W. Garland Ave., Garland.
Pierce, Graham L., 3607 Gaston, Dallas.
Pierce, Robert J. (Int.),
Vet. Adm. Hosp., Dallas.
Pierson, Milton A., 9323 Garland Rd., Dallas.
Pinkston, Lee G., 3305 Thomas Ave., Dallas.
Piranio, Joe C., 606 Monssen Dr., Dallas.
Pirtle, G. William, Jr. (Int.),
John Peter Smith Hosp., Fort Worth.
Popkess, Fred G.,
302 Preston Royal Med. Cen., Dallas.
Porter, George L., 3707 Gaston, Dallas.
Porter, Louis H., II, 3707 Gaston, Dallas.
Portman, Robert K.,
1315 W. Jefferson, Dallas.
Potts, James M. (Hon.),
4100 Caruth, Dallas.
Potts, Robert J., P. O. Box 900, Dallas.
Potts, William H., Jr., Box 28, Dallas.
Poulos, Ernest, 5323 Harry Hines, Dallas.
Powell, Homer (Hon.),
2635 W. Mulberry, San Antonio.
Powers, Hugh W. S.,
8215 Westchester, Dallas.
Pratt, Edward L., 3721 N. Harwood, Dallas.
Prejean, Oran V.,
1317 N. Washington, Dallas.
Price, Harry S., 351 W. Jefferson, Dallas.
Pritchard, Jack A., 5323 Harry Hines, Dallas.
Puls, Richard J.,
610 Med. Arts Bldg., Dallas.
Quinn, Lester H., 3616 Maple, Dallas.
Railsback, George D., Jr.,
2011 W. Irving Blvd., Irving.
Range, N. Haskell, 6331 Prospect, Dallas.
Rattan, Paul M.,
Medical Arts Bldg., Dallas.
Ray, James H., 208 S. Zangs, Dallas.
Read, Edwin P.,
117 N. E. 8th St., Grand Prairie.
Reagan, A. Morriss,
3903 Gaston Ave., Dallas.
Reddick, W. Grady,
Medical Arts Bldg., Dallas.
Reed, William L., Medical Arts Bldg., Dallas.
Regnier, Thomas A., 135 W. 10th St., Dallas.
Reisman, David D.,
3707 Gaston Ave., Dallas.
Renken, Harry J., Jr., 3707 Gaston, Dallas.
Reuss, G. Thomas,
901 Texas Bank Bldg., Dallas.
Reynolds, Jack, Parkland Mem. Hosp., Dallas.
Reynolds, Robert A.,
3707 Gaston Ave., Dallas.
Reynolds, William S.,
1537 Med. Arts Bldg., Dallas.
Rhodes, Edward L. (Int.),
Methodist Hosp., Dallas.
Richardson, Edward R.,
220 Med. Arts Bldg., Dallas.
Richburg, Paul L., 3707 Gaston Ave., Dallas.
Richmond, Marion B.,
3928 Bryn Mawr Dr., Dallas.
Ricketts, Marion M.,
Wynnewood Prof., Bldg., Dallas.
Riddle, Penn, 251 Field St., Dallas.
Riedel, Albert F., Jr. (Int.),
P. O. Box 1769, Dallas.
Rifkin, Leonard M., (Mil.),
516 Med. Arts Bldg., Dallas.
Rippy, Edwin L., 3622 Fairmount, Dallas.
Ritchey, Lloyd F., 8215 Westchester, Dallas.
Roach, Joe G., Jr., 3701 Fairmount, Dallas.
Roberts, Albert D., Jr. (Mil.),
No. 20 Flint Drive, Fort Dix, N. J.
Roberts, Joe H., 101 Iowa Street, Irving.
Roberts, Tom Ray, 6331 Prospect, Dallas.
Robertson, Lester E.,
204 Med. Arts Bldg., Dallas.
Robins, Keith I.,
2710 Valley View Lane, Dallas.
Robinson, Fabian J. (Inac.),
6411 Bandera, Dallas.
Robinson, Wayne T., 3814 Fairmount, Dallas.
Robison, Leonard J., 6003 Victor, Dallas.
Rogers, Fred T., Box 28, Dallas.
Rogers, Gene W.,
3330 S. Lancaster, Dallas.
Rogers, Harriet N.,
County Court House, Dallas.
Rogers, Paul A.,
806 Med. Arts Bldg., Dallas.
Rosenthal, Raoul S., 3524 Fairmount, Dallas.
Ross, Edward S., 2929 Welborn, Dallas.
Ross, James K.,
208 Med. Arts Bldg., Dallas.
Rosser, Curtice,
710 Med. Arts Bldg., Dallas.
Rothschild, J. E., 3707 Gaston Ave., Dallas.
Rounsaville, John Q., 504 W. Tenth., Dallas.
Rountree, John R.,
4 Richardson Hts., Richardson.
Rouse, Milford O.,
1414 Med. Arts Bldg., Dallas.
Rowe, J. Forsythe (Hon.),
1402 Kings Highway, Dallas.
Rowe, Robert J., 3707 Gaston Ave., Dallas.
Royer, Emmett M., (Int.),
9323 Garland Rd., Dallas.
Russell, Melvin G., 936 N. Edgefield, Dallas.
Sacher, Clarence B.,
817 Med. Arts Bldg., Dallas.
Saldivar, Julian T., 3300 Cole Ave., Dallas.
Salem, Samuel D.,
Wynnewood Prof. Bldg., Dallas.
Sams, Lewis C., 201 W. 10th St., Dallas.
Sanders, Morris, 3607 Gaston Ave., Dallas.
Sanders, Wilford M., Jr.,
721 Med. Arts Bldg., Dallas.
Sazama, John J., 3707 Gaston, Dallas.
Scales, John G., 400 West 9th St., Dallas.
Scanland, Viola P.,
623 Med. Arts Bldg., Dallas.
Schaefers, J. G., Jr.,
8215 Westchester, Dallas.
Schenewerk, George A.,
8215 Westchester, Dallas.
Schneider, Peter W.,
206 W. 10th St., Dallas.
Schnitzer, Bernard, 10695 Aledo, Dallas.
Schoch, Arthur G., Medical Arts Bldg., Dallas.
Schonfeld, Murry D.,
1203 Gordon St., Dallas.
Schorlemer, Wendell C., (Int.),
Methodist Hosp., Dallas.
Schreiber, Gus, Jr., 4217 Herschel, Dallas.
Schroeder, Charles F.,
1810 S. Westmoreland, Dallas.
Schuett, Albert J., Medical Arts Bldg., Dallas.

Schulze, John Paul, (Mil.),
James Connally AFB, Waco.
Schwenkenberg, Arthur J.,
210 N. Westmoreland, Dallas.
Scurry, Maurice M., 3710 Swiss, Dallas.
Sears, Alvin D., 3552 Villanova, Dallas.
Sears, William F. (Mil.),
U. S. Army Hosp., Fort Riley, Kan.
Seay, Frank O.,
220 Med. Arts Bldg., Dallas.
Sebastian, F. J., 3707 Gaston Ave., Dallas.
Seely, M. Stuart,
3911 Gaston Ave., Dallas.
Seidel, Clifford C.,
Wynnwood Med. Bldg., Dallas.
Seldin, Donald W.,
2211 Oak Lawn, Dallas.
Selecman, Frank A.,
410 Med. Arts Bldg., Dallas.
Sellars, William A.,
238 W. 10th St., Dallas.
Sellers, Dunham R. (Int.),
Ochsner Foundation, New Orleans, La.
Sellers, Lyle M., 3707 Gaston, Dallas.
Sellman, Willard C.,
922 Med. Arts Bldg., Dallas.
Selman, Forrest B. (Int.),
500 Rice St., Hamilton.
Sewell, James W.,
221 Pleasant Grove Shopping Center, Dallas.
Shane, J. Howard,
1421 Med. Arts Bldg., Dallas.
Shannon, Arthur W., Jr.,
220 Med. Arts Bldg., Dallas.
Shannon, Hall, 1229 Med. Arts Bldg., Dallas.
Shannon, Manning B., 4000 Junius, Dallas.
Shaw, Robert R., 3810 Swiss, Dallas.
Shelburne, Samuel A., 3707 Gaston, Dallas.
Sheldon, Lawrence B.,
Medical Arts Bldg., Dallas.
Shelmire, J. Bedford,
1410 Med. Arts Bldg., Dallas.
Shelmire, J. Bedford, Jr.,
1410 Med. Arts Bldg., Dallas.
Shelton, George L., Jr., 4303 Oakland, Dallas.
Shelton, William P., 8215 Westchester, Dallas.
Shepard, Marvin G.,
722 Med. Arts Bldg., Dallas.
Shinn, Bonner L.,
Wynnewood Prof. Bldg., Dallas.
Shires, Geo. Thomas,
5323 Harry Hines, Dallas.
Shires, Robbie Jo, 10023 Garland Rd., Dallas.
Shoecraft, Warren A., 135 W. 10th St., Dallas.
Short, Robert F., Medical Arts Bldg., Dallas.
Shortal, William W., 4217 Swiss, Dallas.
Shropulos, George P., (Int.),
Parkland Mem. Hosp., Dallas.
Shuey, Charles B., 8215 Westchester, Dallas.
Shuster, Donald W., 4105 Live Oak, Dallas.
Sibley, George W., 630 N. Bishop, Dallas.
Siebel, Eldon K., 201 W. 10th St., Dallas.
Siegel, Robert M.,
110-D Walnut Hill Village, Dallas.
Sigel, Zundel, 1900 Forest Ave., Dallas.
Sigler, Howard Y., 4217 Swiss, Dallas.
Sikora, David, (Int.), St. Paul's Hosp., Dallas.
Sills, E. Garrett, (Mil.),
6534th USAF Disp., Chicksands, England.
Simmons, Belvin A., (Int.),
1910 Province Lane, Dallas.
Simmons, Charles E., (Int.),
Southwest Med. School, Dallas.
Simmons, Robin E., Box 248, Richardson.
Singleton, John D., 3704 Dickason, Dallas.
Slaughter, B. Celia, Box 28, Dallas.
Slaughter, Manuel O.,
2011 W. Irving Blvd., Irving.
Sloan, Charles M., 206 W. Colorado, Dallas.
Smale, John S., 2722 Shelby Court, Garland.
Small, Andrew B., (Pres.),
3707 Gaston, Dallas.
Smart, Don M., 9323 Garland Rd., Dallas.
Smith, Alice L., 3326 Blackburn, Dallas.
Smith, C. Robt., 9323 Garland Rd., Dallas.
Smith, Charles L.,
821 W. Garland Ave., Garland.
Smith, Elsie A., 4922 Greenville, Dallas.
Smith, Lois W., 3524 Fairmount, Dallas.
Smith, Louis S., 3121 Bryan St., Dallas.
Smith, Ralph C., V. A. Hospital, Dallas.
Smith, Richard M., Box 28, Dallas.
Smith, Robert W., 7805 Lake June Rd., Dallas.
Smith, Sydnie G., 3707 Gaston Ave., Dallas.
Smith, Tom E., 2600 Welborn, Dallas.
Smith, Vinny L., (Hon.),
2600 Welborn, Dallas.
Smith, Wright K.,
Southeast Shop. Center, Dallas.
Somer, Joseph, (Mil.), Dallas.
Sorrells, Chas. C., (Hon.),
619 N. Montclair, Dallas.
Sowers, Harry B., 4618 San Jacinto, Dallas.
Sparkman, Robert S.,
1004 N. Washington, Dallas.
Sparr, Richard A.,
Southwestern Med. School, Dallas.
Speegle, Jackson H.,
210 N. Westmoreland, Dallas.
Speegle, Robert E.,
1002 N. Marion Dr., Garland.
Spegal, Doris V., 6115 La Vista, Dallas.
Spence, Harry M., 4105 Live Oak, Dallas.
Spencer, Charles H., 233 W. 10th St., Dallas.
Stack, John W., Box 135, Mesquite.
Stanley, E. Stephen,
714 Med. Arts Bldg., Dallas.
Stanton, Elbert H., 109 S. Delaware, Irving.
Stapp, William F., (Int.),
1912 E. Beach St., Gulfport, Miss.
Starr, Pete J., (Int.),
711 S. Jefferson, Roanoke, Va.
Stayer, David S., 606 Med. Arts Bldg., Dallas.
Stayer, Glenn C., 206 W. 10th St., Dallas.
Stayer, Irene M., 104 E. 2nd, Irving.
Stell, Cecil I., 3617 Fairmount, Dallas.
Steph, Donal W., (Int.),
Parkland Mem. Hosp., Dallas.
Stephenson, James H., (Hon.),
4523 Cedar Springs, Dallas.
Stephenson, W. O., (Hon.), 4005 Hall, Dallas.
Stewart, James K., P. O. Box 900, Dallas.
Stewart, Robert D., 135 Melba, Dallas.
Stiles, Wendel A., Medical Arts Bldg., Dallas.
Stirman, Jerry A.,
Southwestern Med. School, Dallas.
Strauss, Elias, 3707 Gaston, Dallas.
Streitmatter, David E.,
302 Preston Royal Med. Cen., Dallas.
Strickland, Wm. M., Jr., (Int.),
Parkland Mem. Hosp., Dallas.
Stringer, Charles F.,
746 S. Cen. Expressway, Richardson.
Strong, James C., 601 S. Akard, Dallas.
Strother, E. B., (Hon.), 3604 Purdue, Dallas.
Strother, Wm. K., Jr.,
1311 N. Washington, Dallas.
Stuart, John A., Jr., 3207 Turtle Creek, Dallas.
Stuart, Samuel E., 1121 W. Jefferson, Dallas.
Stubblefield, Robt L.,
5323 Harry Hines, Dallas.
Super, Archie R., 418 Med. Arts Bldg., Dallas.
Sutherland, Dan R., 2618 Welborn, Dallas.
Sutherland, Donald A., 1621 Glen Ave., Dallas.
Suttle, R. Courtney,
3406 McFarlin Blvd., Dallas.
Swager, Warren M., Jr., (Mil.),
Federal Correctional Inst., Seagoville.
Sweeney, J. Shirley,
4005 St. Andrews Dr., Dallas.
Talkington, Perry C.,
1420 Med. Arts Bldg., Dallas.
Tandy, Charles C., (Int.),
206 W. Colorado, Dallas.
Taylor, H. Earl, 220 Med. Arts Bldg., Dallas.
Taylor, Vann S., 6222 Northaven Rd., Dallas.
Teel, Theodore T., Jr.,
221 Pleasant Grove Shopping Village, Dallas.
Teng, Hsi Ching, 5323 Harry Hines, Dallas.
Terry, J. Glenn, 1001 St. Joseph, Dallas.
Terry, Jack S., 220 Med. Arts Bldg., Dallas.
Thomas, Harold R., 3707 Gaston, Dallas.
Thomas, Paul J., 3707 Gaston, Dallas.
Thomas, W. Maxwell, 3707 Gaston, Dallas.
Thomasson, A. R., Jr.,
Medical Arts Bldg., Dallas.
Thomasson, A. R., Sr.,
Medical Arts Bldg., Dallas.
Thompson, Barrett M., 218 S. Main, Irving.
Thompson, Jesse E.,
1008 N. Washington, Dallas.
Thompson, L. S., 726 Med. Arts Bldg., Dallas.
Thompson, L. S., Jr.,
726 Med. Arts Bldg., Dallas.
Tigertt, W. D., (Mil.), Dallas.
Tittle, Guy A., 3600 Fairmount, Dallas.
Tobey, Nathan G., 521 N. Washington, Dallas.
Tobolowsky, Dave,
Wynnewood Prof. Bldg., Dallas.
Tocker, Albert M., 8215 Westchester, Dallas.
Tomkies, James S., Medical Arts Bldg., Dallas.
Tomlinson, Jack R., (Int.),
4006½ Swiss Ave., Dallas.
Touchstone, Jay L.,
606 Med. Arts Bldg., Dallas.
Trumbull, Robert A., (Dead).
Tschumy, William O., Jr.,
1616 Med. Arts Bldg., Dallas.
Tsukahara, William, 1400 Forest Ave., Dallas.
Tubb, Cullen L., 220 Med. Arts Bldg., Dallas.
Turbeville, Louis R., 9323 Garland Rd., Dallas.
Uhler, Claude, 226 S. Edgefield, Dallas.
Ulevitch, Herman, 915 St. Joseph, Dallas.
Underwood, George M., Box 28, Dallas.
Vanatta, John C., III,
Southwestern Med. School, Dallas.
Van Cleave, Charles E., 202 W. 10th, Dallas.
Vassallo, Alfred L., 6738 Glendora, Dallas.
Vassallo, Harry R., 4101 Lemmon, Dallas.
Veninga, Frederick W.,
3520 Cedar Springs, Dallas.
Vermooten, Vincent, 3607 Gaston Ave., Dallas.
Vieaux, Jules W., 4227 Herschel, Dallas.
Vineyard, John P., Jr., (Mil.),
U. S. Army Hosp., Ft. Stewart, Ga.
Voltz, Phillip W., Jr., (Int.),
Baylor Univ. Hosp., Dallas.
Votteler, Theodore P., 3524 Fairmount, Dallas.
Waddell, O. Jay, 220 Med. Arts Bldg., Dallas.
Wade, T. W., 4500 Lancaster, Dallas.
Wagner, Wilson O., Carrollton.
Wagoner, Roy D., 182 Casa Linda Pl., Dallas.
Waldman, Morris F., 2618 Oak Lawn, Dallas.
Waldron, W. Doyle, 118 S. Edgefield, Dallas.
Walker, Jack Earl, (Inac.), Nigeria, W. Africa.
Walker, Price M., (Hon.),
2225 Bellefontaine, Houston.
Wallace, Gordon K., Medical Arts Bldg., Dallas.
Ware, Elgin W., Jr., 3707 Gaston, Dallas.
Ware, F. Leon, 2618 Welborn, Dallas.
Warren, Charles H.,
506 Med. Arts Bldg., Dallas.
Wasserman, Eugene, 3607 Gaston, Dallas.
Waterman, William E., (Mil.),
1240 21st S. E. St., Paris.
Watkins, A. B., Seagoville.
Watkins, Margaret, 3503 Fairmount, Dallas.
Weary, Willard B., 3607 Gaston, Dallas.
Webb, Robert W., 4338 Lemmon, Dallas.
Weed, Olga, 2211 Stutz Drive, Dallas.
Weiner, Bernard S.,
113 N. Center, Grand Prairie.
Weiner, David O., 1614 N. Industrial, Dallas.
Weisz, Stephen, 1637 Med. Arts Bldg., Dallas.
Welch, Mark L., 908 Med. Arts Bldg., Dallas.
Wells, James T., (Hon.),
4015 Colonial, Dallas.
West, Ann, 614 Med. Arts Bldg., Dallas.
Whalley, Peggy Joyce, (Int.),
Parkland Mem. Hosp., Dallas.
Wharton, Turner A., 601 S. Akard, Dallas.
White, Claud V.,
3535 Cedar Springs Rd., Dallas.
White, Edward, 523 Med. Arts Bldg., Dallas.
White, Hugh D., 3429 Univ. Blvd., Dallas.
White, Roland L., 10023 Garland Rd., Dallas.
Whitney, David G., 3707 Gaston Ave., Dallas.
Whitten, Merritt B.,
1430 Med. Arts Bldg., Dallas.
Whittlesey, P. E., Jr.,
Wynnewood Med. Bldg., Dallas.
Wilder, Felix F., 1614 N. Industrial, Dallas.
Wilke, Joseph E., Jr., 930 N. Edgefield, Dallas.
Wilkinson, Wallace B., 101 N. Zangs, Dallas.
Willbanks, Otto L., Jr., (Int.),
Parkland Mem. Hosp., Dallas.
Willeford, Carl A., 111 E. Woodin, Dallas.
Williams, Bryan, 3710 Swiss, Dallas.
Williams, G. Raworth,
616 Med. Arts Bldg., Dallas.
Williams, J. O., Jr., (Int.),
Methodist Hosp., Dallas.
Williams, Joseph R.,
2918 Thomas Ave., Dallas.
Williams, Oscar B., Jr.,
6517 Dykes Way, Dallas.
Williams, Owen Dale, (Int.),
St. Pauls Hosp., Dallas.
Williams, Paul C., 3607 Gaston, Dallas.
Wilson, Ben J., 5323 Harry Hines, Dallas.
Wilson, Bruce F., (Mil.),
1902 W. Woodlawn, San Antonio.
Wilson, Charles M., 3707 Gaston, Dallas.
Wilson, Hugh E., III,
5323 Harry Hines, Dallas.
Winans, Henry M., 2703 Oak Lawn, Dallas.
Winans, Henry M., Jr.,
2703 Oak Lawn Ave., Dallas.
Winborn, Claude D., 3707 Gaston, Dallas.
Winkelbauer, Rudolf G., (Mil.),
5th Gen. Hosp., APO 154, N. Y., N. Y.
Winn, Robert E., 8215 Westchester, Dallas.
Winn, Watt W., 2606 Welborn, Dallas.
Wolfe, Joseph, 3609 Cedar Springs, Dallas.
Wolff, Paul M., (Inac.),
6414 Blanch Cir., Dallas.
Wolford, Robert B., (Hon.),
3819 Moler St., Dallas.
Wolfram, Julius, 3707 Gaston Ave., Dallas.
Womack, Jack L., 10753 Preston Rd., Dallas.
Wood, Joe B., 3707 Gaston Ave., Dallas.
Woodard, Gay T., 233 W. 10th St., Dallas.
Woodard, T. Leroy,
207 Med. Arts Bldg., Dallas.

Woodard, William C.,
324 Med. Arts Bldg., Dallas.
Woods, Channing, 4105 Live Oak, Dallas.
Woods, Ozro T., 4105 Live Oak, Dallas.
Woolf, Jack I., 3607 Gaston, Dallas.
Worsham, A. Gordon, 4143 Cole Ave., Dallas.
Wynne, Buck Jim, Jr.,
628 Med. Arts Bldg., Dallas.
Young, John G., 4005 St. Andrews, Dallas.
Young, Ozora F., (Int.),
7601 Inwood, Dallas.
Youngblood, J. Wade,
8215 Westchester, Dallas.

DENTON

Adami, Gilbert E., 500 W. Oak, Denton.
Allen, Joseph H., (Hon.), 1121 Ector, Denton.
Boyd, Dickson K., (Pres.),
525 S. Locust, Denton.
Burgess, H. M., Normal & Scripture, Denton.
Davis, Bert E., Denton.
Finlay, Alexander M., Jr.,
909 Edgewood St., Denton.
Glass, Paul F., Jr.,
Normal & Scripture, Denton.
Gochnour, Runnald W., Justin.
Haggard, Scott, 121 Piner St., Denton.
Hayes, Lindley O., Denton.
Holland, Joseph W., 525 S. Locust, Denton.
Jones, James H.,
Normal & Scripture, Denton.
Kinard, Conrad L., (Sec'y.),
Normal & Scripture, Denton.
Lockwood, Robert M., 526 N. Locust, Denton.
Maddox, Wm. Gordon,
Med. Arts Bldg., Denton.
McClendon, Harry M., Denton.
Miller, Walter S., Jr., 420 Normal, Denton.
Moreland, Virginia L., 526 N. Locust, Denton.
Norgaard, Hal V., 420 Normal, Denton.
Patterson, Tom V., 502 W. Oak, Denton.
Rainone, Frank A., Jr.,
210 N. Poydras, Lewisville.
Remley, William A., 525 S. Locust, Denton.
Schedler, Paul W., 120 W. Oak, Denton.
Schlegel, Harold F.,
220 N. Poydras St., Lewisville.
Shirley, Geraldine W. S., TSCW, Denton.
Short, Bobby J., (Inac.), Denton.
Silverthorne, Mervin C.,
526 N. Locust, Denton.
Thomas, J. David 2017 Brown Dr., Denton.
Weathers, Paul E., Pilot Point.
Wyss, Albert E., 123 Piner St., Denton.

ELLIS

Baker, Edmund F., Ennis.
Clark, J. Lawrence,
710 N. Preston St., Ennis.
Compton, John G., Jr.,
201 Ferris Ave., Waxahachie.
Curby, John H., (Hon.), Maypearl.
Donnell, Herbert, Waxahachie.
Dykes, Arthur O., Italy.
Estes, Ted G., Waxahachie.
Gough, Edgar F., (Hon.), Waxahachie.
Gray, Clarence E., (Hon.), Ennis.
Hastings, Miles E., Waxahachie.
Jeter, James R., Ennis.
King, John D., Waxahachie.
Kochevar, Gerald J., Midlothian.
McCall, Walter P., Ennis.
McLean, Raymond N.,
201 Ferris, Waxahachie.
Montgomery, John M., (Sec'y.),
Box 547, Milford.
Silman, James B., Water & Ferris, Waxahachie.
Skrivanek, Daniel A.,
200½ W. Knox St., Ennis.
Skrivanek, Ervin J.,
200 W. Knox St., Ennis.
Stein, Ben, Ferris.
Story, Fred L., Ennis.
Swanson, La Verne R., Box 488, Ferris.
Tenery, R. Mayo, Waxahachie.
Tenery, William C., Waxahachie.
Thomas, Anton L., (Hon.), Ennis.
Wallace, B. C., Waxahachie.
Watson, Seaborn H., (Hon.), Waxahachie.
West, Norman L., (Pres.),
112½ S. Rogers, Waxahachie.

FANNIN

Biggers, Lawton C., 200 W. 5th, Bonham.
Donaldson, James M., Bonham.
King, Jack A., Bonham.
Morgan, Lewie E., 200 W. 5th, Bonham.
Risser, Joe A., Bonham.
Sellers, Sidney P., Honey Grove.
Stevens, Joe L., 200 W. 5th, Bonham.
Williams, Ethelbert C., (Sec'y.),
200 W. 5th, Bonham.

GRAYSON

Ackert, Joseph W.,
114 S. Mirick Ave., Denison.
Bates, L. C., 202 N. Walnut St., Sherman.
Bilder, Joseph Jr., 112 N. Burnett, Denison.
Blassingame, W. Doak, Box 131, Denison.
Bonner, Dickson P.,
207 W. Mulberry, Sherman.
Boyd, Arthur M., (Sec'y.),
Box 177, Sherman.
Brandt, Donald H., 213 N. Barrett, Denison.
Britton, Morris L.,
600 N. Highland Ave., Sherman.
Brown, Hubert L., 207 W. Mulberry, Sherman.
Brown, W. Herbert,
106½ S. Rusk, Denison.
Carter, Wilbur, 207 W. Mulberry, Sherman.
Castleberry, Lawrence M.,
Wilson & Jones Hosp., Sherman.
Clayton, Stanley L.,
101 Barrett Bldg., Denison.
Donaghey, Charles J., 603 N. Travis, Sherman.
Duncan, Robert W., 106½ S. Rusk, Denison.
Ellis, John W., Med. Arts Clinic, Sherman.
Enloe, David C., M. & P. Bk. Bldg., Sherman.
Essin, Emmett M.,
600 N. Highland Ave., Sherman.
Etter, Edward F., 207 W. Mulberry, Sherman.
Fowler, Forrest F., Box 657, Denison.
Freeman, Don W., 112 N. Burnett, Denison.
Frietsch, Werner H., Barrett Bldg., Denison.
Fry, Wilburn S., Jr., 2301 S. Austin, Denison.
Geers, Paul E., Whitewright.
Gerard, Rene G., 509 S. Mirick, Denison.
Gleckler, Arthur, 207 W. Mulberry, Sherman.
Gleckler, John D., (Pres.),
211 N. Fannin Ave., Denison.
Hailey, Eugene L. (Hon.),
Barrett Bldg., Denison.
Hardy, John M.,
600 N. Highland Ave., Sherman.
Jackson, Van R.,
600 N. Highland Ave., Sherman.
Jensen, Andrew O., 103 Barrett Bldg., Denison.
Jones, Reed W., Jr., 931 West Main, Denison.
Lay, James V. M., 207 W. Mulberry, Sherman.
Miller, Frank P., P. O. Box 680, Sherman.
Mize, William B., 207 W. Mulberry, Sherman.
Monroe, Stanley E.,
600 N. Highland Ave., Sherman.
Moorman, Thomas A.,
114 Barrett Bldg., Denison.
Norman, Lois L.,
203 M. & P. Bk. Bldg., Sherman.
Reid, Creighton,
600 N. Highland Ave., Sherman.
Roberson, Wilbur G.,
301 M. & P. Bk. Bldg., Sherman.
Robinson, Dean G., Van Alstyne.
Rowland, Robt. H.,
600 N. Highland Ave., Sherman.
Shelton, Fred W.,
600 N. Highland Ave., Sherman.
Shytles, Harry M.,
600 N. Highland Ave., Sherman.
Southerland, Wm. I.,
207 W. Mulberry, Sherman.
Sporer, Frank M., Van Alstyne.
Stoolfire, Arthur W.,
Med. Arts Clinic, Sherman.
Stout, Henry I., (Hon.),
301 M. & P. Bk. Bldg., Sherman.
Stout, Joseph H.,
301 M. & P. Bk. Bldg., Sherman.
Strother, Coble D.,
M. & P. Bk. Bldg., Sherman.
Townsend, Shirley E.,
207 W. Mulberry St., Sherman.
Triplett, M. Neal,
207 W. Mulberry, Sherman.
Tuck, Vernon L.,
300 M. & P. Bk. Bldg., Sherman.
Weisberg, Maurice A., Barrett Bldg., Denison.
Woodward, Max R.,
203 M. & P. Bk. Bldg., Sherman.

HOPKINS-FRANKLIN

Hanna, W. Ray, 525 Church, Sulphur Springs.
Hodges, Lester A.,
395 Houston, Sulphur Springs.
Kirkpatrick, Omer F.,
395 Houston, Sulphur Springs.
Longino, Joseph B.,
530 N. Davis, Sulphur Springs.
Longino, S. Byrd,
530 N. Davis, Sulphur Springs.
Longino, Stephen B., Jr.,
530 N. Davis, Sulphur Springs.
Stirling, Earl, (Pres.), Sulphur Springs.
Swindell, Samuel W., (Sec'y.),
525 Church, Sulphur Springs.
Walling, Otto C., Jr., Mt. Vernon.

HUNT-ROCKWALL-RAINS

Allen, Clarence G., Commerce.
Becton, Joseph D., 4200 Stuart St., Greenville.
Carruthers, F. S., 3714 Lee St., Greenville.
Crim, E. Truett, 4005 Wesley St., Greenville.
Davis, James W., Box 248, Leonard.
Fair, Richard H., 4200 Stuart St., Greenville.
Hinkle, Richard A.,
3724 O'Neal St., Greenville.
Jenks, Ralph W., 3916 Park St., Greenville.
Jones, Robert F., Commerce.
Leberman, Lowell H., Commerce.
Little, Frank J., Greenville.
Maier, Henry W.,
Greenville Bk. Bldg., Greenville.
McConnell, Bernard E., Greenville.
Mehmert, Henry E., Greenville.
Morris, John W., 3410 Wesley St., Greenville.
Philips, William P., Greenville.
Reeser, Wayne, 3502 Lee St., Greenville.
Savage, Carroll D., Greenville.
Seyler, Louis W., (Pres.), Commerce.
Sheldon, Clifford C.,
4200 Stuart St., Greenville.
Strickland, Thos. C.,
2417 O'Neal St., Greenville.
Trentham, J. C.,
203 Med. Arts Bldg., Greenville.
Turbeville, Fred M., Greenville.
Vallancey, John C., (Sec'y.),
4005 Wesley St., Greenville.
Weis, Charles B., 4005 Wesley St., Greenville.

KAUFMAN

Alexander, Gough H., Terrell.
Bowman, Ralph F., Jr.,
202 West Nash, Terrell.
Conradt, Louis W., (Pres.),
Alexander Hosp., Terrell.
DeVlaming, William, Kaufman.
Friddell, Delmas T., Terrell.
Goode, Emmett P., P. O. Box 58, Terrell.
Hall, Edward I., Kaufman Clinic, Kaufman.
Holton, Robert W., Sr., (Hon.), Terrell.
Jackson, Seaton J., 612 S. Rockwall, Terrell.
Lane, Early D., Terrell.
Leinart, O. Scott, Jr., Terrell.
Otero, Manuel J., (Sec'y.),
Terrell State Hosp., Terrell.
Patteson, James L.,
Terrell State Hosp., Terrell.
Ricketts, Harry M., Jr.,
American Natl. Bk. Bldg., Terrell.
Riddle, Napoleon B.,
101 N. Houston St., Kaufman.
Rowell, Robert C., Terrell.
Shands, Percy C., (Hon.), Mesquite.
Shaw, Guy G., Jr., Kaufman.
Smith, William J. B.,
Terrell State Hosp., Terrell.
Walker, Christine Z., Forney.

LAMAR-DELTA

Barker, Carl D., 930 Clarksville, Paris.
Barker, Nym L., (Sec'y.),
930 Clarksville, Paris.
Beachley, Charles E., Jr.,
811 Bonham St., Paris.
Breneman, Fairfax V.,
412 1st Natl. Bk. Bldg., Paris.
Chancellor, Harbert C.,
Clayton Bldg., Honey Grove.
Clifford, James L., 856 Lamar Ave., Paris.
Cooke, Lane B., 740 6th St. S. W., Paris.
Fitzpatrick, William W., (Hon.),
637 Clarksville St., Paris.
Frank, Charles H., 811 Bonham St., Paris.
Gilmore, Clarence E., (Pres.),
811 Bonham St., Paris.
Hammond, D. Scott, 811 Bonham, Paris.
Hayden, William D., 810 Lamar Ave., Paris.
Hillhouse, Joseph F.,
1st Natl. Bk. Bldg., Paris.
Hunt, Harold E., 150 8th St., S. E., Paris.
Hunt, Thomas E., (Hon.),
150 8th St., S. E., Paris.
Hunt, Thomas E., Jr., 150 8th St., S. E., Paris.
Janes, Olen G., Janes Hosp. and Clinic, Cooper.
Janes, Oscar G., 117 E. Dallas, Cooper.
Janes, Osler Y.,
Janes Hosp. and Clinic, Cooper.
Johnson, Malcolm L., 805 Clarksville, Paris.

Jopling, Anna H., 811 Bonham St., Paris.
Jopling, Julian L., 811 Bonham St., Paris.
Kerbow, Dock F., 811 Bonham St., Paris.
Lewis, Donald R., 811 Bonham St., Paris.
Lewis, Robt. L., (Hon.),
811 Bonham St., Paris.
Miesch, David C., 827 Fitzhugh, Paris.
O'Neill, Owen R., 546 Pine Bluff St., Paris.
Parchman, Hugh W., 810 Lamar, Paris.
Powell, James N., (Hon.),
210 Lib. Natl. Bk. Bldg., Paris.
Robinson, Oscar W., Paris.
Townsend, Courtney M., 930 Clarksville, Paris.
Walker, Marcellus A., 810 Lamar, Paris.
White, Hal H., (Hon.), Paris.
Woodfin, George S., 811 Bonham, Paris.

VAN ZANDT

Baker, Horace A., Wills Point.
Cozby, Raymond W., Grand Saline.
Fry, Harry T., (Hon.), Wills Point.
Garrett, Wm. J., Van.
Golladay, Robert M., Box 307, Wills Point.
Hilliard, George H., Jr., Canton.
Marsh, George B., Jr., Grand Saline.
Sanders, D. Leon, (Hon.), Wills Point.

FIFTEENTH DISTRICT

Dr. H. O. Padgett, Marshall, Councilor.

BOWIE

Baldridge, Max, 401 E. Fifth St., Texarkana.
Barnes, Walter C., 401 East Fifth, Texarkana.
Bintliff, Charles V., 520 Pine St., Texarkana.
Brunazzi, Richard R.,
6th and Walnut Sts., Texarkana.
Calhoun, John G., Jr.,
2304 New Boston Rd., Texarkana.
Carney, Henry M., 619 Main St., Texarkana.
Chappell, Robert H.,
Wadley Bldg., Texarkana.
Daniel, Noble B.,
317 State Line Ave., Texarkana.
Davis, Elmer L.,
317 State Line Ave., Texarkana.
Dawson, William D.,
317 State Line Ave., Texarkana.
Ellison, Eugene T., 619 Main St., Texarkana.
Frost, Jack E., New Boston.
Goesl, Andrew G., (Pres.),
317 State Line Ave., Texarkana.
Good, Louis P., 401 East 5th St., Texarkana.
Harrell, William B.,
317 State Line Ave., Texarkana.
Harrison, Robert K.,
420 W. 6th St., Texarkana.
Hawkins, Henry A., New Boston.
Hibbitts, William,
Texarkana Natl. Bk., Texarkana.
Hughes, Mary Witt, (Sec'y.),
2401 State Line, Texarkana.
Hughes, Raymond P.,
Texarkana Natl. Bk., Texarkana.
Jones, John W., 401 E. 5th St., Texarkana.
Kitchens, Chester E.,
723 Main St., Texarkana.
Klein, Cyrus P., 517 Pine St., Texarkana.
McGee, Ellis B., New Boston.
McGee, Joel R., (Hon.), New Boston.
Parson, George W., Box 778, Texarkana.
Roberts, A. Warren,
Texarkana Natl. Bk., Texarkana.
Robison, James T.,
6th and Walnut Sts., Texarkana.
Rorie, Jean E., 619 Main St., Texarkana.
Schneble, Richard J.,
401 E. 5th St., Texarkana.
Smith, Charles A., 723 Wood St., Texarkana.
Smith, Charles G., 525 Olive St., Texarkana.
Stuart, Charles C., 420 W. 6th St., Texarkana.
Tyson, William S., Jr., New Boston.
Ward, Harold L., Box 1017, De Kalb.
Williams, Marvin L., 619 Main St., Texarkana.

CAMP-MORRIS-TITUS

Baber, Dunbar H., (Hon.), Daingerfield.
Ball, James E.,
1114 N. Jefferson, Mt., Pleasant.
Chandler, Henry E., (Hon.), (Dead).
Ellis, John M., (Pres.),
Box 107, Mt. Pleasant.
Fender, Ernest L., Jr., Mt. Pleasant.
Hardman, Robert L.,
1114 N. Jefferson, Mt. Pleasant.
Johnson, Robert L., Pittsburg.
King, William A., P. O. Box 727, Omaha.
Lee, James F., Gen. Del., Daingerfield.
Leeves, James S., (Sec'y.), Naples.
McKellar, Lee D.,
605 N. Madison, Mt. Pleasant.
Pendergrass, Robert K., Pittsburg.
Philips, Harry O., Lone Star.
Reitz, Percy A., Pittsburg.
Renfroe, Thomas W., Mt. Pleasant.
Rutledge, Lowell E., Daingerfield.
Smith, Donald R., P. O. Box 956, Daingerfield.
Smith, U. Lee, P. O. Box 657, Daingerfield.
Taylor, William A., Mt. Pleasant.
Taylor, Willis A., (Hon.), Mt. Pleasant.
Tom, John C., Jr., Box 184, Mt. Vernon.
Wheat, E. Baxter, (Hon.), Daingerfield.
Wise, Charles J., Naples.

CASS-MARION

Brooks, Jesse M., Atlanta.
Brooks, M. James, Jr., Atlanta.
Bucy, Roy S., Box 32, Linden.
DeWare, Jesse M., III, 403 Vale, Jefferson.
Glenn, Vernon B., Jr., Box 32, Linden.
Grumbles, Ernest W., Atlanta.
Joslin, Blocker H., Atlanta.
Nichols, Joe D., Atlanta.
Nichols, Thomas K., Atlanta.
Steed, Thurmon M., Jr., Hughes Springs.
Taylor, Orville R., Jr., Linden.
Terry, William S., Jefferson.
Wilcox, Louise N., (Sec'y.),
Box 308, Hughes Springs.
Woods, Andrew J., Jefferson.

GREGG

Adams, James N.,
210 Mobberly Ave., Longview.
Adams, Joe E., 904 Houston St., Kilgore.
Allums, Loraine L., 316 Henderson, Kilgore.
Andres, Ben, Med. Surg. Clinic, Longview.
Awalt, Elmer W., 324 Glover-Crim, Longview.
Barker, William E.,
315 1st Natl. Bk. Bldg., Longview.
Bloom, Charles S., (Sec'y.),
Box 512, Gladewater.
Buckner, Edwin E., Marshall & 7th, Longview.
Cave, Walter, 2027 S. High, Longview.
Clanton, Benj. Reid, Box 591, Longview.
Crawford, Ralph C., 408 Mobberly, Longview.
Crawley, Henry K., 320 South St., Kilgore.
Dingler, Clark M., Jr.,
418 S. Mobberly, Longview.
Downs, Seth R., 316 Henderson Blvd., Kilgore.
Dworin, Jack W.,
Med. & Surg. Clinic, Longview.
Echols, Robert B., 320 South St., Kilgore.
Elkins, Oliver W.,
211 Bramlette Bldg., Longview.
Farrar, William P., P. O. Box 2266, Longview.
Farrington, Evan S.,
318 1st Natl. Bk. Bldg., Longview.
Fleming, John W., Jr., Kilgore.
Hancock, A. R., Gladewater.
Hardwick, Robert S., 400 N. Third, Longview.
Hart, Walter F.,
107 W. Quitman St., Gladewater.
Hoover, George M.,
315 1st Natl. Bk., Bldg., Longview.
Hudspeth, Ray, (Pres.),
312 N. Main, Gladewater.
Johnson, Cecil A.,
621 N. 4th St. Longview.
Johnson, James H., Jr.,
200 N. Fredonia St., Longview.
Jones, Ernest L.,
417 1st Natl. Bk. Bldg., Longview.
Khoury, Sam G., 213 North First, Longview.
Langston, William B., Jr.,
418 1st Natl Bk. Bldg., Longview.
Leake, Bain, Gladewater.
LeBus, Howard E., P. O. Box 809, Gladewater.
Loftis, John R., Jr., 210 Mobberly, Longview.
Mack, Sam, 621 N. 4th St., Longview.
McGrede, Henry C., Jr.,
305 1st Natl. Bk. Bldg., Longview.
McKean, Jesse C., Gladewater.
McKellar, G. G., S. W. Reserve Life, Longview.
McRee, Judson T., Longview.
Mondrik, Frank V.,
603 North 6th St., Longview.
Moser, Emil R., Gladewater.
Nichols, Carl, Gladewater.
Norman, Wayman B., Box 66, Longview.
Ott, William M., 1101 S. Martin, Kilgore.
Parrish, Wilmer E.,
Med. & Surg. Clinic, Longview.
Payton, Calvin W., Box 2386, Longview.
Rappeport, Joseph H.,
621 N. Fourth, Longview.
Robberson, G. W. Jack,
1006 Henderson Blvd., Kilgore.
Roberts, Joe D., Box 266, Longview.
Robertson, Rowland H., Jr.,
East Main St., Kilgore.
Routon, William M., Kilgore.
Rushing, Garland S.,
Med. & Surg. Clinic, Longview.
Salmon, David D., 611 S. Green St., Longview.
Simmons, D. C., 901 E. Main, Kilgore.
Spalding, James C.,
104 East Hwy 80, Greggton.
Swinney, Bluford A.,
139½ East Tyler, Longview.
Tate, George W., Box 889, Longview.
Van Sickle, R. J., 100 East Methvin, Longview.
Velinsky, Morris, Kilgore.
Watkins, E. O., 200 Pine Tree Rd., Greggton.
Wensley, John E., 2016 S. High, Longview.
Wilkinson, Jacques D.,
621 N. 4th St., Longview.

HARRISON

Allen, Edgar H., Jr., (Sec'y.),
210 N. Lafayette, Marshall.
Bennett, George E., (Pres.),
402 S. Bolivar, Marshall.
Cariker, Mildred, Kahn Mem. Hosp., Marshall.
Carter, Ray H., 406 W. Austin, Marshall.
Conerly, Fred S., P. O. Box 272, Marshall.
Crayton, Philip L., 210 N. Lafayette, Marshall.
Dieste, Antonio, P. O. Box 272, Marshall.
Farquhar, George A.,
Kahn Mem. Hosp., Marshall.
Granbery, Richard G.,
402 S. Bolivar, Marshall.
Harmon, Roger Q., Jr.,
401 Pinecrest Dr. E., Marshall.
Harris, James H., Box 193, Marshall.
Heidelberg, Charles H.,
401 Pinecrest Dr. E., Marshall.
Holcomb, Norman F.,
308 W. Houston, Marshall.
Kemper, Thomas W.,
401 Pinecrest Dr. E., Marshall.
Littlejohn, Frank S.,
401 S. Bolivar, Marshall.
McNatt, Malcolm,
210 N. Lafayette, Marshall.
Murphy, Maurice H., 402 S. Bolivar, Marshall.
Padgett, Harold O., Box 749, Marshall.
Redding, Leman M., 300 N. Alamo, Marshall.
Tenney, Samuel W., 402 S. Bolivar, Marshall.
Wyatt, Charles A.,
1501 S. Washington, Marshall.

RED RIVER

Atkinson, Charles N.,
210 Pierce St., Clarksville.
Brooks, Earl E., Bogata.
Edwards, Rex L., (Sec'y.),
504 N. Walnut, Clarksville.
Marx, Melvin Jr., Clarksville.
Payne, Ross W., Clarksville.
Reed, Charles B., Clarksville.
Wright, James L., Clarksville.

UPSHUR

Fenlaw, Joseph L., Gilmer.
O'Keefe, John B., (Sec'y.), Box 203, Gilmer.
Ragland, Hugh M., Gilmer.
Ragland, Madison S., Gilmer.